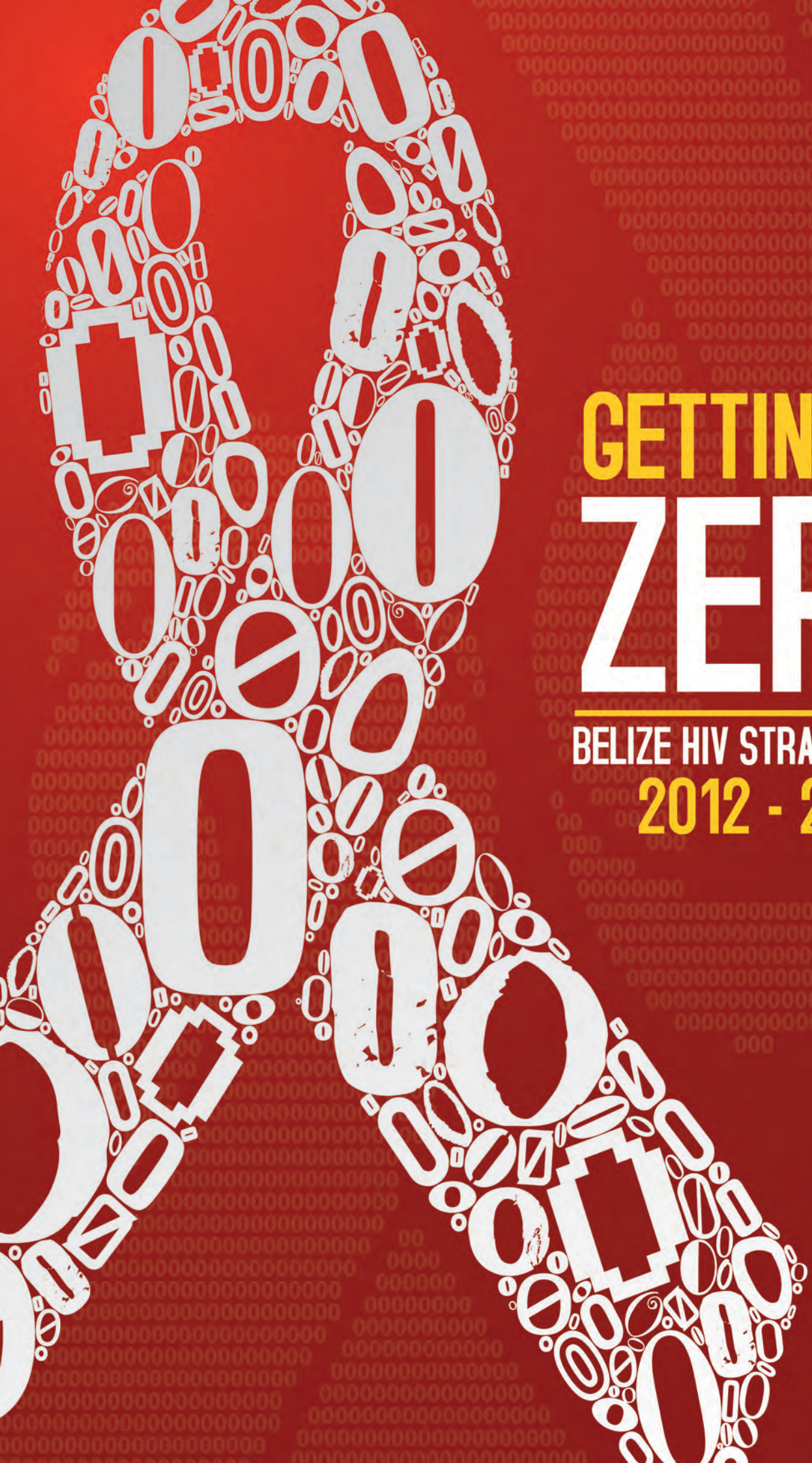


# GETTING TO ZERO

## BELIZE HIV STRATEGIC PLAN

## 2012 - 2016

one response

The USAID | Program for Strengthening the Central American Response to HIV (USAID | PASCA) is funded by the U. S. Agency for International Development (USAID) under Contract No. GPO-I-00-05-00040-00, beginning in October 1, 2008. It is implemented by Futures Group International, LLC (Futures Group), in collaboration with the Futures Institute. USAID | PASCA is Task Order 4 under the USAID | Health Policy Initiative. This document is made possible by the support of the American people through the United States Agency for International Development (USAID). The contents of this document do not necessarily reflect the views of USAID or the United States Government.

# Foreword

The completion of this National Strategic Plan marks an important step in the ongoing development of the national response to the HIV epidemic in Belize. It is an important and most recent milestone in a process that saw the setting up of the National AIDS Task Force (1996) and subsequently the National AIDS Commission (2003); the adoption of the National HIV Policy (2006), the National HIV/AIDS Workplace Policy (2006), the National Strategic Plan (NSP) for 2006-2011 and the National Monitoring and Evaluation Plan of the NSP 2006 – 2011 (2008). It speaks to further advancing the multi-sectoral approach that has begun to show positive results both in Belize and internationally.

The revision of the 2006-2011 NSP reflects two new key realities. Firstly, in the programmatic areas, it acknowledges the past achievements that allow it to put a focus on the specific issues that continue to fuel the epidemic. Gender responsiveness and reduction of stigma and discrimination are cross-cutting intervention areas. The NSP develops the broad outline of the national response and turns it into a blueprint for action, delineated in the accompanying National Operational Plan (NOP). The total process was not a dry academic exercise but rather was developed in consultation with the broadest possible group of partners and stakeholders, including persons with and /or vulnerable to HIV. It is a living document that represents Belize's desire to take responsibility for directing its own national response to HIV. The NSP will assist greatly in coordinating and directing the efforts of Belizean and international agencies, thus avoiding overlap in some areas and filling the gaps in others. It should not be viewed as a static document but rather as a work in continuous progress.

Secondly, the NSP attempts to articulate the need to find and put in place new approaches to partnerships, mainstreaming and sustainable financing to compensate for the expected loss of attention and resources. Over the last three decades, advances in the global and local clinical and technical responses to HIV have contributed to it being categorized as a chronic disease. In addition, the HIV response in Belize is confronted with the emerging pressures on and threats to public health by non-communicable diseases (NCD). WHO calculations over 2004 show that the estimated "burden of disease" caused by HIV/AIDS is "only" 3.9% of Belize's total burden of disease[1]; and that the combined impact of NCD is 53 % while the combined impact of NCD and Injuries is close to 75 %. These figures show that changes in efficiency, effectiveness and financing will have to occur in order to keep a meaningful response to this disease. We, therefore, invite all interested parties to join us as we set out to turn our plans into a lasting reality.

[1] WHO: http://www.who.int/healthinfo/global_burden_disease/gbddeathdalycountryestimates2004.xls

# Table of Contents


| | | |
|---|---|---|
| Foreword | | 3 |
| Table of Contents | | 4 |
| Acronyms | | 5 |
| Key Terms | | 8 |
| Executive Summary | | 9 |
| Chapter One | Overview | 12 |
| Chapter Two | Ending New HIV Infections | 16 |
| Chapter Three | Improving Health and Wellbeing | 33 |
| Chapter Four | Creating an Enabling Environment | 48 |
| Chapter Five | The National Strategic Plan 2012 – 2016 | 72 |
| Chapter Six | Monitoring, Evaluation and Indicators for NSP 2012-2016 | 77 |
| Chapter Seven | The National Operational Plan | 81 |
| References | | 82 |

# Acronyms

| | |
|---|---|
| AAA | Alliance Against AIDS |
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BCC | Behaviour Change Communication |
| BDF | Belize Defence Force |
| BFLA | Belize Family Life Association |
| BHIS | Belize Health Information System |
| BSS | Behavioral Surveillance Survey |
| CAREC | Caribbean Epidemiology Centre |
| CCM | Country Coordinating Mechanism |
| CHART | Caribbean HIV/AIDS Regional Training Network |
| CITC | Client-Initiated Testing and Counselling |
| CML | Central Medical Laboratory |
| CNET+ | Collaborative Network of Persons Living with HIV |
| CSEC | Commercial Sexual Exploitation of Children |
| DBS | Dried Blood Spots |
| ELISA | Enzyme-Linked Immuno-Sorbent Assay |
| EPP | Estimation and Projection Package |
| FSW | Female Sex Workers |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GOB | Government of Belize |
| HFLE | Health and Family Life Education |
| HIV | Human Immunodeficiency Virus |
| HSRP | Health Sector Reform Project |
| IEC | Information, Education, and Communication |
| ILO | International Labour Organization |
| LGBT | Lesbian, Gay, Bi-Sexual and Trans-Gender |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MHDST | Ministry of Human Development and Social Transformation |
| MOEY | Ministry of Education and Youth |
| MOH | Ministry of Health |

| | |
|---|---|
| MOLLGRD | Ministry of Labour, Local Government and Rural Development |
| MSM | Men who have Sex with Men |
| NAC | National AIDS Commission |
| NAC C&T | NAC Care and Treatment Sub-Committee |
| NAC IEC | NAC Information, Education and Communication Sub-Committee |
| NAC M&E | NAC Monitoring and Evaluation Sub-Committee |
| NAC P&L | NAC Policy and Legislation Sub-Committee |
| NAP | National AIDS Programme |
| NASA | National AIDS Spending Assessment |
| NCD | Non-Communicable Diseases |
| NCPI | National Composite Policy Index |
| NGO | Non-Governmental Organization |
| NMEP | National Monitoring and Evaluation Plan |
| NOP | National Operational Plan |
| NSP | National Strategic Plan |
| OIs | Opportunistic Infections |
| OVC | Orphans and Vulnerable Children |
| PAHO | Pan American Health Organization |
| PANCAP | Pan Caribbean Partnership against HIV/AIDS |
| PASMO | Pan American Social Marketing Organization |
| PITC | Provider Initiated Testing and Counseling |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PSM | Procurement and Supplies Management |
| REDCA+ | Central American Network of People Living with HIV |
| SBS | Sexual Behaviour Survey |
| SRH | Sexual and Reproductive Health |
| STI | Sexually Transmitted Infection |
| SW | Sex Workers |
| UNAIDS | United Nations Joint Programme for HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children Efficiency Fund |
| VCT | Voluntary Counseling and Testing |

| | |
|---|---|
| WHO | World Health Organization |
| WIN | Women's Issues Network |
| YES | Youth Enhancement Services |
| YFF | Youth For the Future |
| YWCA | Young Women's Christian Association |

# Key Terms

**Affective Partners is** someone with whom a person has intimate relations and shares a mutual emotional bond.

**Determinants** are used to describe the underlying structural and social factors, such as institutional culture, poverty, gender norms, human rights attitudes that increase people's vulnerability to HIV infection.

**Evaluation** and analytical reviews provide strategic information that enables policymakers and Programme managers to steer policy formulation and strategy planning towards sustainable outcomes.

**Expected Results** are representations of what success would look like. Most HIV strategies include broad goals, usually related to prevention, care and treatment, and specific results that would help achieve the goals, expressed in terms of coverage, utilization and behavioral change.

**Goals** are statements of vision and direction, describing what the strategy aims to achieve (e.g. reduced HIV incidence)

**Impact** – the highest level in the results chain, this refers to longer term ultimate goals, such as reducing HIV incidence, improved survival and health of persons with HIV.

**Indicators** measure progress towards targets. For example, an indicator of condom use might be the percentage of men who reported using a condom at their last sex act.

**Inputs** are resources – money, people, equipment, supplies and know-how, which combine to produce outputs.

**Monitoring** refers to data collection, compilation and review, so that it is possible to see what progress is being made, and make programmatic adjustments to improve progress.

**Operation Plans** (also called Work Plans or Action Plans) define the detailed activities that will contribute to strategy results, as well as who is responsible for undertaking them, the cost of each activity, and a timetable.

**Outcomes** – the second level of results in a results chain – refer to access to and use of services (e.g. number of people tested for HIV and counseled coverage of percent of pregnant women who access Prevention of Mother-To-Child-Transmission services) and behaviour changes (e.g. use of condoms).

**Outputs** are the products and services needed to achieve outcomes. These are the first level of results in a results chain.

**Strategies** (also called National Strategic Frameworks/Plans) provide a picture of the chosen approaches for trying to achieve the results that the country wants to deliver.

**Vulnerability** results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection.

(*Source: UNAIDS AIDS Strategy and Action Plan Guidelines, 2007)*

# Executive Summary

In Belize, the highest expenditures in the health sector increasingly occur in the response to non-communicable diseases (NCD), that create a "burden of disease" far greater than HIV/AIDS. This trend requires a more efficient and effective national response to HIV that is built on a mainstreamed sustainable financing scheme. With this in mind, the National AIDS Commission and its partner organizations set out to formulate, through an intensive round of working sessions and consultations, the National Strategic Plan (NSP) 2012-2016. The plan aims to provide reference and guidance to the country's multi-sectoral response to HIV, as well as to function as a tool for the mobilization of domestic and foreign resources.

The document delineates three priority areas that speak to the response dimensions of ending new HIV infections, improving health and wellbeing, and creating an enabling environment for the response. In each area the document provides insight into the situation parameters, the on-going response actions, a deeper root cause analysis (including a Problem Tree) and a mapping of the extracted remaining gaps.

The analysis establishes that Belize has halted and started to reverse the spread of HIV, however, we assume that pockets of continued new infections remain. The document identifies the successes in the prevention of mother-to-child transmission we see this as critical, as well as key vulnerable groups that continue to play a crucial role in the determinants of the epidemic and whose sexual behavioral patterns show a continued high level of vulnerability to HIV. Response-frames therefore need to become more evidence-informed in targeting these groups and in designing high impact interventions; this is certainly the case for behaviour change communication for young men and women, men who have sex with men, sex workers, incarcerated persons and mobile populations.

Treatment indicators show a mix of achievements and pending improvements. The positive trend of increased ART coverage puts the country on track to achieve the Universal Access goals. More challenging are the performance parameters that are connected to medication options and monitoring drug resistance, short-term survival rates and adherence, as well as matters linked to diagnosis and treatment of other STIs and the detection of Opportunistic Infections. Challenges remain in the roll-out of integrated services within the Continuum of Care where clinical management should seamlessly connect to medical, nursing care and psycho-social and material support to establish quality of life and well-being for persons infected and/or affected by HIV/AIDS.

The NSP 2012-2016 builds on the established paradigm of the Three Ones coupled with the concept of multi-sectoral participation in the design, implementation and oversight of the response frame work, involving many key organizations of the public sector and civil society. Applying the rights-

based approach and using the logical causal pathway framework, the plan identifies a number of critical systemic areas that need urgent attention for the establishment of an enabling environment. A call is being made to effectively focus on the reduction and mitigation of HIV-based stigma and discrimination, at the level of legislation and policies of the state as well as at the level of institution-based service provision and the wider public opinion. The plan calls for a louder voice and a greater involvement of the affected groups in crafting and implementing response mechanisms and holding actors accountable for the implementation of the NSP 2012 – 2016. The plan identifies the need to address three other systemic weaknesses; although experiencing certain weaknesses, the national response mechanism is well established and needs to reach out for the strengthening of the community-based responses within the Continuum of Care; comprehensive HIV services need to be integrated and incorporated into existing service delivery structures, which are sustainable in the longer term, leading to better efficiencies and value for money; and the need to improve the national systems and mechanisms for the generation, compilation, analysis and use of key data and information.

On the basis of the extraction of the pending issues and gaps in the national response, the NSP delineates its three priority areas: i) Ending New HIV-Infections (Prevention); ii) Improving Health and Well-being (Treatment, Care and Support); and iii) Creating an Enabling Environment (Coordination of the National Response) and postulates four main goals:

1. **By 2016, Belize has halted and began to reverse HIV incidence rates, especially among young people, men who have sex with men and sex workers.**
2. **By 2016, AIDS-related deaths, especially among men living with HIV in Belize, will have decreased by 30%.**
3. **By 2016, systems will be in place to fully understand the essential features of the epidemic in Belize.**
4. **By 2016, Belize will have significantly reduced discrimination against persons vulnerable to HIV.**

The three priority areas are provided with specific Strategic Objectives that provide a scope of content and direction of the sub-areas and each strategic objective is accompanied by a set of expected results at outcome or output level. Expected results enable the performance monitoring and the plan therefore includes a rudimentary set of key performance indicators that constitute the foundations for the NSP's monitoring and evaluation plan.

In line with the plan's inclusion of an imperative for the strategic management of data and information, the plan assigns high value to the planning of the various layers of monitoring and

evaluation of the NSP, including the increase of relevant research. It also emphasizes the embedding of the NSP Monitoring and Evaluation Plan into the National Monitoring and Evaluation System. The National Operational Plan (NOP), which will immediately follow the NSP, will descend to the level of concrete actions in each of the priority areas. It will be focused on the concrete activities, actors and timelines that deliver the output contributing to the achievement of the higher level outcomes. The NOP will also form the instrument that will contribute to a comprehensive costing of the NSP.

# Chapter 1 Overview

## *1.1 Purpose of the National Strategic Plan and the National Operational Plan*

The National Strategic Plan (NSP) and the accompanying National Operational Plan (NOP) seek to: document the evidence related to the key determinants of the epidemic in Belize, draw lessons learned from the past ten years of the response, engage the participation of key stakeholders in programme planning and implementation, set clear programme goals and priorities for the future of the HIV response, estimate the financial and human resource needs of the response and enhance collaboration and coordination among all stakeholders, while establishing a results framework to measure performance. The NSP aims to guide the country's multi-sectoral response to HIV, as well as act as an aid for the mobilization of resources.

The NOP is the blueprint that translates the objectives and results of the NSP into activities and actions that contribute to the achievement of the overall goals outlined in the NSP. The link between the NSP and the NOP is one that seeks to ensure that the results defined in the NOP have a logical relationship with the outcomes in the NSP.

## *1.2 Process of the Development and Formulation of the NSP-NOP*

Under the auspices and guidance of the National AIDS Commission (NAC), the stakeholders in the national HIV response developed the NSP 2012-2016. A Strategic Planning Oversight Working Group was appointed by the NAC to provide guidance to the consultants contracted. The overall formulation and development of the NSP involved a series of activities, including literature review, desk reviews, gap analyses and sector consultations. The desk reviews included a study and analysis of key national assessments, including but not limited to, the Analysis of the Situation and Response to HIV in Belize (2011)[2]; the Policy Implementation Monitoring Tool Report (2011)[3]; the UNGASS 2010 Country Progress Report[4]; the AIDS Programme Index 2008/2009[5]; the National AIDS Spending Assessment (2010)[6]; the Situational Analysis of Most at Risk Populations (2010); the Gender-based. Analysis of HIV in Belize (2010); Actions on Ending Violence Against Women in Belize (2010);

[2] Describes the current state of the HIV/AIDS epidemic and the national response in Belize, including the mapping of key implementers, intervention areas, locations and populations reached, and highlights key challenges, gaps and opportunities.
[3] Aims to identify advances, challenges and opportunities in the implementation of a particular policy.
[4] A comprehensive overview of the country's progress during 2008–2009 in achieving the commitments of the UNGASS Declaration.
[5] Measures the extent to which the policy environment is supportive of an effective response to HIV/AIDS, as well as relevant changes in the same period
[6] Tracks the actual expended funds –international, public, and private– that comprises the national HIV/AIDS response.

Evidence of Gender Risk Factors to HIV in Belize (2009); the Millennium Development Goals Scorecard and Report (2010); the Report on Reproductive Health and HIV among young persons in Belize 2010; the 2010 Annual Report of the National TB, HIV and other STIs Programme, and the Rapid Assessment of Vulnerable Groups to HIV in Belize (2009). The review also focused on international and regional commitments such as the UN Political Declaration on HIV/AIDS (2011), the Millennium Development Goals (MDGs), the Mexico Ministerial Declaration as well as the Caribbean Regional Strategic Framework 2008-2012. The overall objective was to provide an overview of the situation, identify advances and remaining gaps, review recommendations for next steps and utilize these to complete the conceptual and logical strategic framework of the revised NSP.

The Strategic Planning Oversight Committee developed a roadmap to guide the completion of the strategic planning process in Belize, including the development of the NSP, NOP, M&E Plan, and Financial Gap Analysis. In the development of the NSP, consultations were held with members of the NAC district committees and standing committees, as well as with vulnerable populations such as men who have sex with men (MSM), sex workers (SW), youth, women and persons with HIV. The objective was to identify needs and gaps based on their experiences so as to inform the NSP and NOP development processes. Principles underlying the strategic and operational plan were identified to ensure the plan is human rights-based, inclusive, gender responsive and in line with the Three Ones Principles as delineated by UNAIDS.

## *1.3 Structure of the National Strategic Plan document*

Chapter 1 provides an introductory overview in which purpose, development process, and the structure of the NSP document are explained and which additionally provides a basic profile of the country.

Chapters 2-4 describe, for each of the three selected priority areas, a number of specific dimensions and dynamics including a situation description detecting quantitative and qualitative trends in some of the main manifestations; an overview of the response up to present, a display and description of the root-cause overview ("the problem tree"); and a description of the main remaining gaps and needs that inform the development and content of the NSP 2012 - 2016.
The root-cause overview has taken the concise format of the problem tree which allows for a graphical vision of the cascading chain of causes and effects. The top segment of the problem tree depicts the main manifestation (e.g. continued HIV transmissions) and the cascading text boxes contain the most likely answers to the "Why?" question, which is repeated at every level; the text boxes in the upper parts therefore describe the more immediate causes of the main manifestation, while the text boxes in the lower part highlight the underlying root causes. This allows for a strategic identification of critical interventions.

Chapter 5 provides the articulations of the NSP. It introduces the guiding principles that underpin the plan and explains the main characteristics of the plan: the vision, the overall and specific goals and targets. For each of the three priority areas, an overview is provided of the plan's principal strategies, strategic objectives and expected results. This information is summarized in the Results Framework.

Chapter 6 describes in summary form the most salient elements of the monitoring and evaluation strategy and a reference is made to the National Monitoring and Evaluation Plan (NMEP) which will be developed upon adoption of the NSP 2012 - 2016. To that extent, the section also includes a rudimentary NSP indicator frame work that can serve as the basis for the development of the NMEP. The document concludes with a short reference to the NOP (Chapter 7) and provides an overview of reference materials that were utilized during the formulation process of the NSP.

## *1.4 Basic Country Profile*

**Geography and Demographics**

Belize lies on the Caribbean coast of Central America bordered by Mexico to the North and Guatemala to the West and South. Belize, the only English-Speaking Caribbean country in Central America, is a multi-ethnic society comprising many cultures and languages including the Creole, Mestizo, Garifuna, East Indian and indigenous groups such as the Mopan and Ket'chi Mayas. Belize has an estimated population of 312,698[7] resulting in a population density of 37.6 persons per square mile. The male –female ratio is very close to 1:1; 63 % of the population is under the age of 30; 48.4 % was under 19 years and 36.8 % under the age of 15. The elderly (60 years and older) accounted for 7.1% and women of child-bearing age (15-49 years) for 46.2 % of the total female population. The dependency ratio was 45.2 in 2005 as compared to 82.4 in 2007. The annual population growth of Belize is estimated at 3.4 %. Half the population (51.9 %) lives in urban areas. The Belize District is the largest administrative district (30.0 % of the total population), followed by the Cayo district (24.2 %).

**Poverty**

The 2009 Country Poverty Assessment (CPA) reports that approximately one third of Belize's households live below the poverty line, with 10% of all households classified as indigent. An additional 13% of all households were vulnerable to poverty. At population level, the poverty level stands at 41.3% (28% of the urban population and 55% of the rural population).[8] The poorer populations were less likely to seek medical assistance, more likely to use public rather than private health facilities, and less likely to have health insurance. The Gross Domestic Product (GDP) per

[7] Preliminary findings, Census 2010, Statistical Institute of Belize
[8] Belize, Living Standards Measure Survey, 2009

capita is estimated at BZ$ 8,134.83. Added to the high levels of poverty in Belize is the high unemployment rate of 8.5% with women facing higher unemployment rates than men, with Stann Creek and Toledo districts reporting the highest rates of unemployment (11.5% and 14.9% respectively). The adult literacy rate of Belize is estimated to be 76%. Poverty-connected deprivations such as poor sanitation and hygiene, lack of educational opportunities and unemployment are contributory factors that increase the susceptibility of persons within this population to HIV infection.

**Key Overall Health Indicators**

Population indicators show that Belize is in the third phase of demographic transition, which is characterized by declining crude birth rates (21.9 X 1,000 population), a stable crude death rate (4.0 X 1,000 population), continued population growth that is predominantly driven by high levels of immigration, and an increased burden of non-communicable, communicable, and degenerative diseases on population mortality. The overall HIV prevalence rate of Belize is the highest in Central America and the fourth highest in the Caribbean. Based on currently available data, it continues to be argued that Belize is experiencing a generalized epidemic with higher HIV prevalence concentrated in pockets of the population. Mortality from AIDS, malignant neoplasms of the lung and breast, and circulatory diseases has shown a notable increase. The leading causes of death for all ages (2008) were primarily NCD[9].

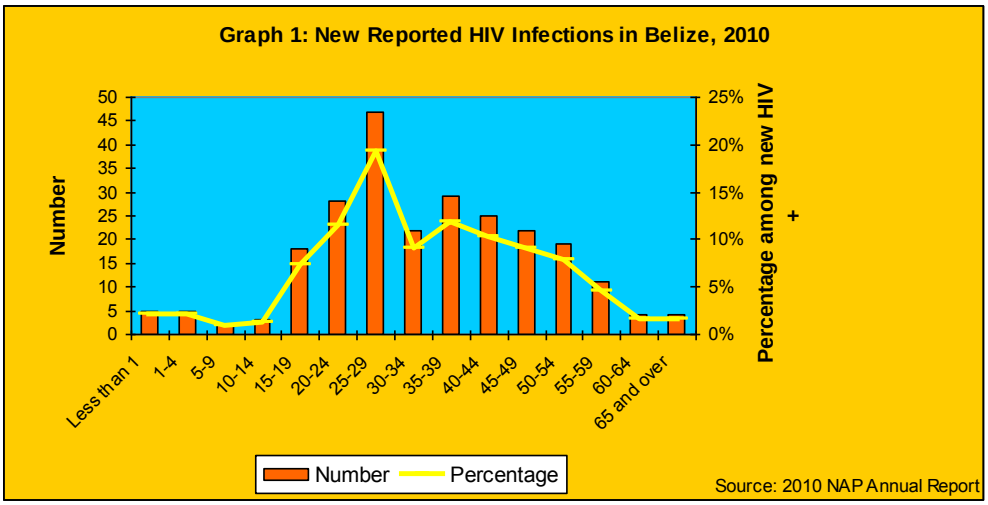
[9] Belize Country Poverty Report, 2010

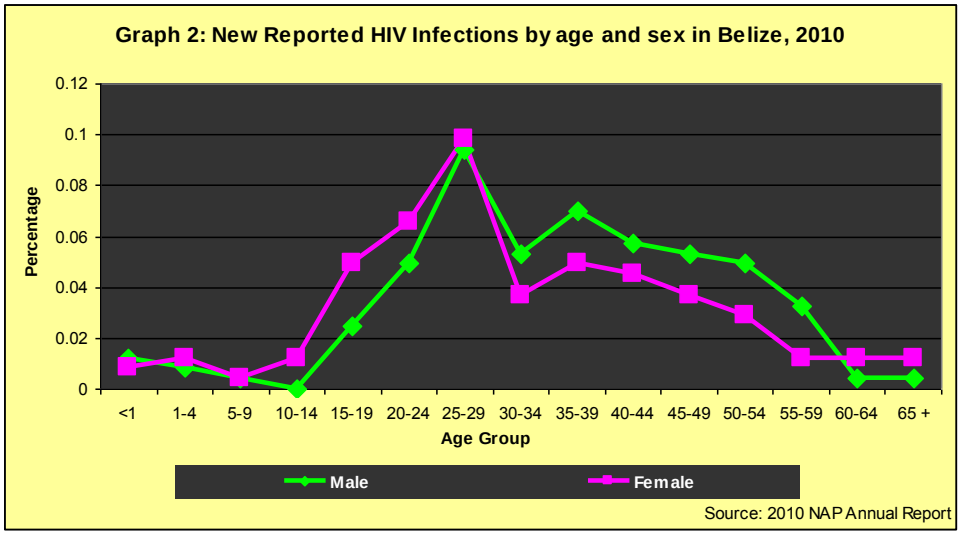
# Chapter 2 Ending New HIV Infections

## *2.1 The Situation*

### HIV Prevalence and Incidence in the General Population and Among Youth

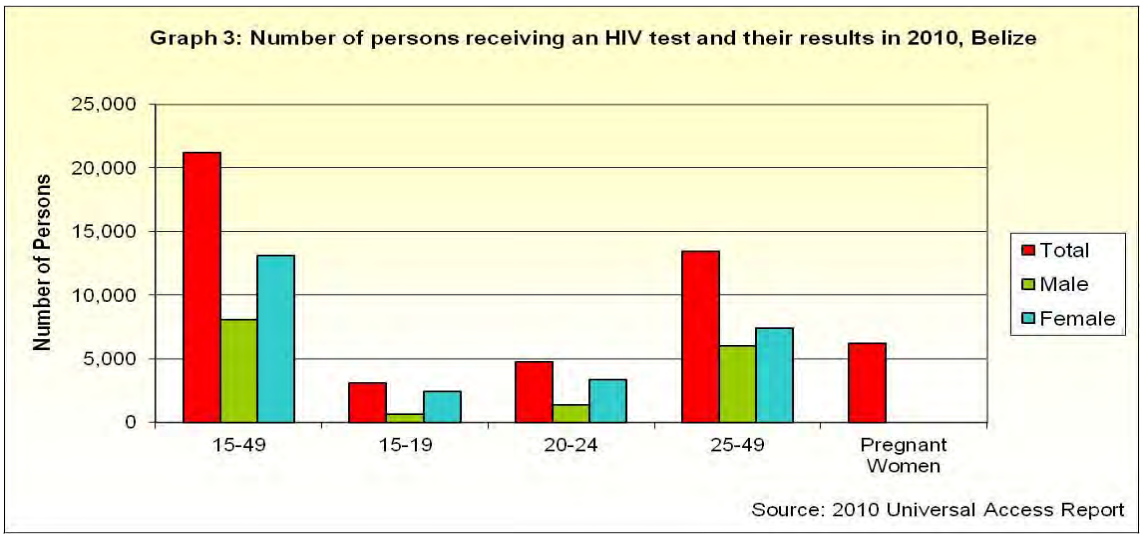
The adult HIV prevalence rate of Belize was calculated at 2.3 [2.0-2.8][10] in 2009, and has remained relatively unchanged compared to the rate in 2001 of 2.2 [1.9-2.6]. In the same year, the overall prevalence rate among antenatal clinic attendees was 0.99%, with a rate of 1.01% among 15-24 year old pregnant young women[11]. Using the Estimation and Projection Package (EPP) to estimate and project adult HIV prevalence and incidence from surveillance data in Belize, the number of adults and children with HIV was estimated to be 4,800 [4000-5700] in 2009, up from 3,600 [3000-4200] in 2001[10]. EPP estimates put the prevalence rate of young women age 15-24 at 1.8 [1.4-2.7], more than double the rate for young men in the same age range (estimated at 0.7 [0.5-1.1][10]). In 2010, the total number of newly diagnosed HIV Infections was 244[12], indicating a decrease of 33.8% in the number of newly diagnosed HIV infections, compared to the




[10] Global report: UNAIDS report on the global AIDS epidemic, 2010
[11] Belize UNGASS Report 2010
[12] National TB, HIV and other STIs Programme: Annual Report, MOH 2010

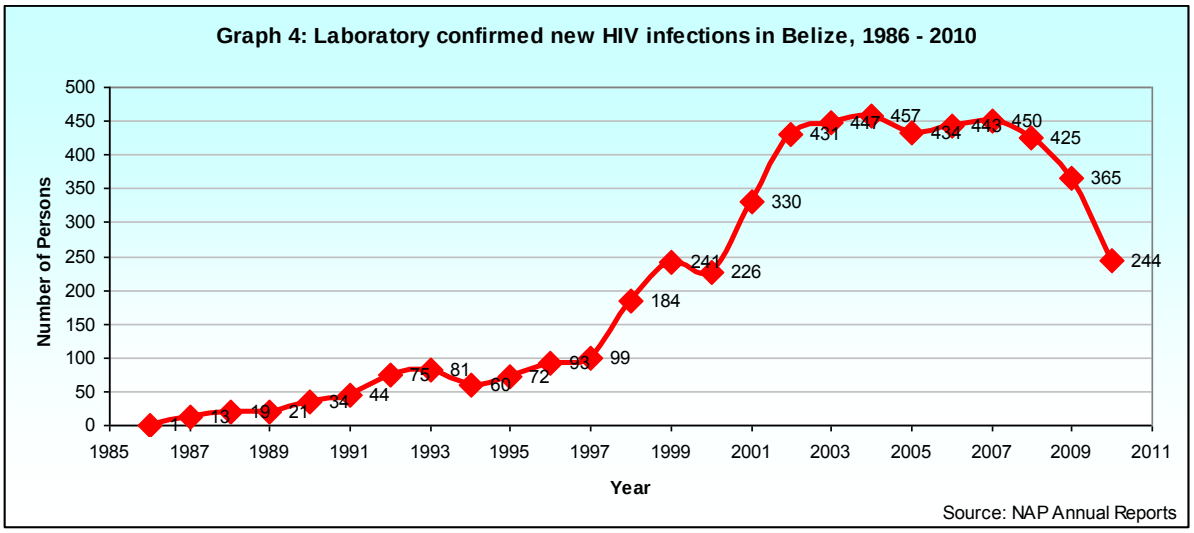
year 2009. Compared to 2008, the total reduction of new HIV infections over these two years is around 43%. This trend provides an indication that Belize has halted and started to reverse the spread of HIV (MDG 6). The key age group of the population most affected remains the age cohort 20 – 49 years, with the highest number of reported new HIV infections in the age group 25-29 years. Graph 2 shows that newly reported HIV cases for young persons under the age of 25 occur more among females than among males. In the age group 15-19 years, the rate of reported new infections for girls is twice the rate for boys; in the age group 25-29 the sex ratio is close to 1: 1 but in the age group 50-59, the rate of reported new infections for men is twice the rate for women.




The number of HIV tests has been relatively stable over the past five years at approximately 16,000 – 20,000 tests per annum. The fact that approximately 60% more tests are being administered to females generally correlates with testing in the antenatal care setting, with pregnant women accounting for 29.2% of the total number of tests administered. Females, age 15-19 years, are four times as likely to be tested for HIV when compared to the males of the same age group[13]. Graph 3 shows the distribution of HIV testing in 2010 in the age group 15-49. Persons 15-19 years of age were least likely to be tested (14.5%) while the majority of tests in this age group are taken by females. It must be noted that due to barriers to accessing sexual and reproductive health (SRH) services without parental consent, including HIV testing and treatment, young persons under the age of 18 are less likely to be tested and that HIV testing in the age group 10-18 is primarily occurring during antenatal visits of pregnant teens. Similarly, persons aged 20-24 represented less than 25% of all tests conducted, with 70.7% of the tests in this age group administered to females. Despite lower testing rates, young people age 15-29 years account for the largest portion of newly diagnosed HIV infections. This provides an indication of higher HIV infection rates in this sub-population. Significant focus needs to be placed on attaining universal access to prevention, treatment, care and support services for adolescents and young people in Belize.

[13] Belize Universal Access Reports 2007-2010, MOH

Additionally, men are testing in much lower rates than women in all age groups. This coincides with the poor health-seeking behaviour of men. Despite having lower testing rates than females in the age group 25-49 years, men account for a larger percentage of the new HIV diagnosis in this age range. More attention needs to be placed on greater involvement of men in SRH services and innovative initiatives are needed for male-centred information, education and behaviour change communication. In 2002, routine voluntary counselling and testing (VCT) services were introduced, which coincided with an increased number of confirmed HIV infections. Between 2003 and 2007 the number of reported new HIV infections was constant at an average of 440 per annum. The Ministry of Health (MOH) expanded the Provider Initiated Testing and Counselling (PITC) approach to the health care system in 2008 and the HIV module of the Belize Health Information System (BHIS) was rolled out in 2009, improving efficiency in managing health data. The year 2008 also marked the first year of the declining trend in reported new HIV infections in Belize.




**Geographic Distribution of HIV in Belize**

Unlike previous years, when the Belize and Stann Creek districts showed higher HIV incidence rates, the Belize and Cayo districts now report the highest incidence rates while Stann Creek District ranks third. The variations in the geographic distribution are mainly attributed to migration, both from neighbouring countries as well as internal migration of the indigenous population, workers in the tourism industry, public servants and officers from the uniformed services.

**HIV Prevalence and Incidence in Specific Populations**

Belize is considered to have a generalized epidemic. The estimated prevalence rate in pregnant women has consistently been below 1% for the past 5 years, allowing us to theorize that there are concentrated pockets in the population with higher prevalence rates. In Belize, MSM, SW, prisoners and young people are assumed to be disproportionately affected by HIV[14]. Other at-risk groups include the uniformed services, migrant and mobile populations and persons with disabilities. There

[14] National HIV/AIDS Epidemiologic Profile 2003 to 2007, Ministry of Health

is, however, little epidemiological information to substantiate that these groups are in fact at a higher risk. HIV in injecting drug users has not presented itself as an issue in Belize although more investigation is needed on the link between drug and alcohol abuse and the higher risk of HIV transmission.

There is a significant data gap in Belize as it relates to second generation surveillance; sero-prevalence surveys have only been conducted among the prison population of the Belize Central Prison in 2005 and the Belize Defence Force (BDF) in 2009, where prevalence rates are 4.9% [2.7%-6.0%][15] and 1.14% [0.03%-2.3%][16] respectively. In 2011, MOH embarked on the Behavioral Surveillance Survey (BSS) of HIV/STI Prevalence and Risk Behaviours in Most-at-Risk Populations in Belize, which is anticipated to provide population size estimates, HIV sero-prevalence rates and sexual risk behavior data for MSM and female sex workers (FSW).

In the absence of empirical evidence, the assumption has been made that there are higher infection rates in specific vulnerable populations in Belize. This assumption is based on the analysis of data from countries in the Latin America and the Caribbean regions with similar social and cultural norms (see Table 1). Most of the HIV epidemics in Latin America and the Caribbean region are concentrated in and among MSM with prevalence rates ranging from 6.7 % in Suriname to 31.8% in Jamaica. HIV prevalence rates among FSW continue to be higher than for the general population with values varying from 4.8% in the Dominican Republic to 24.1% in Suriname. Prisoners who do not have the same access to public health programmes and services also exhibit higher rates than the general population ranging from 2.0% in the Bahamas to 5.2% in Guyana.

**Table 1: Prevalence of HIV among MSM, FSW and Prisoners in the Caribbean 2005-2009**

| Country | Adult Prevalence | HIV Prevalence among MSM | HIV Prevalence among FSW | HIV Prevalence among Prisoners |
|---|---|---|---|---|
| **The Bahamas** | 3.1 | 8.2 | NA | 2.0 |
| **The Dominican Republic** | 0.9 | 11.0 | 4.8 | 2.6 |
| **Guyana** | 1.4 | 19.4 | 17.0 | 5.2 |
| **Haiti** | 2.6 | NA | 5.0 | NA |
| **Jamaica** | 1.9 | 31.8 | 5.0 | 3.3 |
| **Suriname** | 1.0 | 6.7 | 24.0 | NA |
| **Trinidad and Tobago** | 1.2 | 20.0 | NA | NA |
| Source: Keeping the Score 3, UNAIDS 2010 | | | | |

[15] Gough E, Edwards P. HIV sero-prevalence and associated risk factors among male inmates at the Belize Central Prison.
[16] A Serological and Behavioral Assessment of HIV Infection in the Belize Defense Force, 2010

**Prevention of Mother-to-Child Transmission (PMTCT) of HIV**

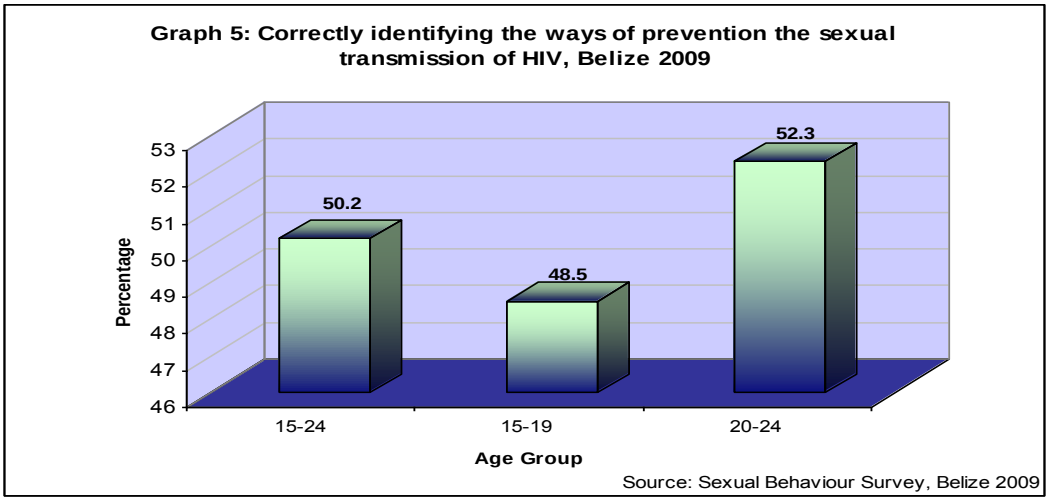
The Prevention of Mother-to-child Transmission (PMTCT) Programme in Belize has been touted as a best practice in the region. Given that over 90% of pregnant women in Belize utilize the antenatal care at the public facilities and as 95% of all births occur in hospitals, assisted by skilled attendants, the decision was taken at the inception of the programme to integrate PMTCT services into the Maternal and Child Health (MCH) Programme. In 2007 there were 62 positive pregnant women and 17 babies who were HIV-positive; in 2008 there were 65 HIV-positive pregnant women and 3 HIV-positive babies. The HIV-infected babies were born predominately to HIV-infected mothers who did not access appropriate antenatal care. There was also significant improvement of the treatment protocol, moving from the single dose nevirapine, offered during active labour and to their newborns, to the provision of prophylaxis to pregnant women at 14 weeks of gestation. The programme also included the integration of a strategy to reduce congenital syphilis into the PMTCT programme.

**Table 2: Key indicators of the PMTCT Programme, Belize 2006-2010**

| Year | Pregnant Women | Pregnant Women Tested for HIV | HIV Testing Coverage | HIV+ Pregnant Women | HIV Prevalence among Pregnant Women |
|---|---|---|---|---|---|
| **2006** | 7,218 | 6,290 | 87% | 61 | 0.97% |
| **2007** | 7,017 | 6,325 | 90% | 62 | 0.98% |
| **2008** | 7,045 | 6,552 | 93% | 65 | 0.99% |
| **2009** | 7,018 | 6,310 | 90% | 63 | 0.99% |
| **2010** | 6,626 | 6,178 | 93% | 53 | 0.86% |
| Source: NAP MOH 2010 | | | | | |

In 2010, 93.2 % of all registered pregnant women (6,631) were tested, of whom 53 (0.86 %) tested positive (see Table 2). Over 98 % of HIV-positive pregnant women received ARV during pregnancy or at the time of delivery and over 98 % of the new-borns received ARV prophylaxis at birth. Of the pregnant women detected to be HIV-positive in 2010, 37.7 %[17] were documented as "known HIV-positive cases", the majority of which were repeat unplanned pregnancies. This level of unplanned repeat pregnancies among HIV-positive women has fluctuated in recent years, which averages between 30- 45 %.

[17] National TB, HIV and other STIs Programme; Annual report 2010; Ministry of Health




**Knowledge and Sexual Behaviour among young people**

In 2009, 50.2 % of young people 15-24 years of age correctly identified both consistent condom use and having one uninfected partner, who has no other partners, as ways of preventing the sexual transmission of HIV. The scores in the age groups 15-19 and 20-24 were 48.5% and 52.3%[18] respectively.

An assessment of reported consistent condom use during sex with multiple partners and during sex with non-regular partners shows that rates reported by persons 25-49 years were low with females reporting lower percentages than males. The age group 15–19 reported overall higher levels of consistent use of condom for sex with multiple partners and non-regular partners than the age group 20-24. Overall, females reported lower levels of consistent use of condoms with non-regular partners and multiple partners than males, with the exception of 20-24 year olds with multiple partners. The 2009 SBS indicated that approximately 36% of persons aged 15-24 reported having an HIV test in the 12 months prior to the interview and knowing their result.

**Table 3: Consistent Condom Use With Multiple Partners and Non-Regular Partners**

| | | Sex | | |
|---|---|---|---|---|
| | **Age Group** | **Both** | **Male** | **Female** |
| **Consistent Condom Use with multiple partners** | 15-19 | 73.7 | 80.8 | 58.3 |
| | 20-24 | 71.6 | 70.4 | 76.9 |
| | 25-49 | 58.0 | 60.7 | 50.0 |
| **Consistent Condom Use with non-regular partners** | 15-19 | 60.5 | 69.2 | 41.7 |
| | 20-24 | 56.7 | 59.3 | 46.2 |
| Source: SBS, Belize 2009 | | | | |

[18] Sexual Behaviour Survey (SBS) 2009

**Knowledge and Sexual Behaviour among at-risk groups**

In 2009, the Pan-American Social Marketing Organisation (PASMO) Belize conducted a second round of an HIV/AIDS TRaC Study[19], evaluating condom use among FSW and MSM in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek districts. Condom use among these groups showed diverging directions, however, both studies highlight that the consistent use of condoms has decreased[20].

The survey was conducted among 252 FSW, of whom 88% were from fixed venue locations and 12% were ambulatory. The survey showed a decrease in condom use at last sex between FSW with their new clients as well as their affective partners, but an increase of condom use with their occasional and regular clients. Overall condom use among FSW interviewed increased slightly from 93.3% in 2007 to 95.8% in 2009. 36.7% of FSW reported consistent condom use with their affective partners in the last month compared to 87.2% with their occasional clients. Notably, the percentage of FSW carrying a condom on them at the time of the interview, decreased from 77.5% in 2007 to 46.9% in 2009. Overall consistent condom use in the last month with any partner or client decreased to 35.3% in 2009 compared to 60.1% in 2007. The percentage of FSW reporting having had an HIV test in the year prior to the interview also decreased to 68.5% in 2009 compared to 75.8% in 2007. Knowledge of ways of preventing HIV improved over the period 2007 to 2009, however, this did not result in corresponding improvements in the behaviour change indicators. There is limited data available about FSW in rural areas, where access to HIV and SRH services is limited.

The TRaC study also surveyed 227 MSM, of whom 72% identified themselves as gay; 21.5% as bi-sexual; 4.0% as heterosexual; and 2.5% as trans-gender. Reported condom use at last sex with occasional partners decreased, but increased with all other partners. Overall, reported condom use at last sex decreased from 85.4% in 2007 to 79.6% in 2009. Reported consistent condom use in the last month with any partner decreased from 72.0% in 2007 to 63.6% in 2009. In 2009, 77.4% of MSM interviewed reported having had an HIV test in the year prior to the interview and 61.7% of them reported having a condom on them at the time of the interview. MSM reported an average of 10.7 sexual partners in the last month in 2009, up from 8.6 in 2007.

A rapid assessment conducted in Belize in 2009[21] noted that mobile and migrant populations are predominantly the unskilled workers in agriculture, construction and service industries; it is estimated that 10% of the adult population in Belize are migrants. In the formative assessment for the agriculture sector in 2005, conducted by the Ministry of Labour, most participants could correctly identify the modes of transmission. Similarly, findings from the *Workers Survey* reported

[19] Population Service International. Belize HIV/AIDS TRaC Studies Evaluating Condom Use among MSM & FSW: Second Round. Washington, DC: PSI, 2009

[20] idem

[21] Situation Analysis Desk Study related to Most At Risk Population (MARPs) in Belize, 2009, NAC

that 97.7% of the respondents correctly identified the modes of transmission, notwithstanding the perseverance of myths surrounding the transmission of HIV, in particular the belief that *mosquito bites* can transmit the HIV virus.

The 2010 BDF Sexual Behaviour Study[22] reported on specific behaviours within the national army, identifying personnel at risk for HIV infection. Among the 31.1% of the soldiers who reported sex with a sex worker during the previous 12 months, 26.3% reporting not using a condom during their last sexual contact with a sex worker. Over 50% of the interviewees reported not knowing the HIV status of their last sexual partner. Additionally, over 50% reported having more than one partner in the last 12 months, while 25.9% reported having more than one partner in the preceding 30 days, with 35.1% reporting that their partner in the last 30 days also had multiple partners. 44.4% of the respondents admitted to engaging in sexual coercion in the last 12 months and 4.1% reported exchanging sex for drugs, food or money. Also notable was the limited knowledge about PMTCT programs and the availability of ART treatment.

## *2.2 The Response: Prevention Services*

**Mass Communication:** MOH has been implementing on an annual basis nation-wide "Know Your Status, Get Tested Today Campaign" throughout the year and especially during World AIDS Week activities. In addition, mass media are used to inform and educate the general public on PMTCT. PASMO is one of the principal civil society organisation implementing mass media campaigns in the country. These campaigns are primarily geared towards condom use through the "Got it. Get it" slogan. Belize also benefits from the regional mass media campaign "Live Up!" which is delivered through the local affiliate of the Caribbean Broadcasting Corporation. The Belize Family Life Association (BFLA) also uses mass media to promote SRH services as well as condom use. The Belize Red Cross uses billboards to bring awareness through the "Faces" campaign. The current Global Fund (GFATM) Round 9 grant to the Belize CCM is filling an important gap in mass media campaigns by targeting young persons with a Behaviour Change Communication (BCC) campaign addressing delayed sexual activity among in-school youth, and a mass media campaign, using creative BCC television and radio messages, to promote safer sexual practices and partner reduction among out-of-school youth, 15-24 years old. This is also a first attempt to design and deliver a coordinated national mass media campaign targeting young people, based on and guided by evidence gathered from the Belize SBS of 2009.

**Targeted and Community Outreach:** Prevention initiatives, targeting other sub-populations assumed to be at risk, are mainly guided by anecdotal evidence. Consequently, MOH is currently undertaking

[22] A Serological and Behavioral Assessment of HIV Infection in the Belize Defense Force

an exercise to estimate the population sizes for MSM and FSW, as well as conducting behavioural and sero-prevalence surveillance in these populations through the assistance of the Centers for Disease Control and under the guidance of the Universidad del Valle de Guatemala. Notwithstanding this, organisations provide prevention services to targeted groups based on perceived vulnerability. The Youth For the Future (YFF) department of the Ministry of Education and Youth (MOEY) provides young persons who are out-of-school with information and education on ways of preventing the transmission of HIV. The NGOs, Youth Enhancement Services (YES) and Young Women's Christian Association (YWCA), provide young girls, at-risk of early pregnancy and HIV infection, with advocacy, education, and economic empowerment services. The Alliance Against AIDS (AAA) provides services to persons with HIV, including educational and prevention programmes. In 2008, AAA initiated, in collaboration with the Women's Issues Network of Belize (WIN-Belize), the Sexual Health and Sexuality Education Programme as a New Prevention Technology for women in urban and rural areas. The programme includes the training of educators on Sexual Health and Sexuality, as well as outreach with women in poor neighbourhoods and rural villages. Target audiences include Community Nurses Aides, youth, MSM, prisoners and persons with HIV. The newly formed NGO of and by persons with HIV, "C-NET+" (Collaborative Network of People Living with HIV), is the primary counterpart for REDCA+ (the Central American Network of persons with HIV) and is a sub-recipient of a regional GFATM grant. The grant aims to contribute to increased levels of participation of persons with HIV in key actions for change as well as deliver a broad spectrum of capacity, leadership and empowerment building opportunities among persons with HIV. BFLA also provides outreach services to sexually diverse populations in Belize, including SRH education to youths, MSM, FSW, and persons from the lesbian, gay, bi-sexual and trans-gender (LGBT) community. With funding from the US Department of Defence, and guided by the results of the SBS of 2009, the Charles Drew University initiated in 2010 a three year project to provide HIV education and prevention services to BDF soldiers.

**Schools:** MOEY has made significant advances in strengthening the Health and Family Life Education (HFLE) programme in primary schools. Apart from having reached primary school students, MOEY has been able to train 152 secondary school students as peer educators in the Stann Creek and Toledo Districts. It has also opened Youth Friendly Spaces, designed and used as a safe place, where students can access information (literature, brochures and documentaries) on HIV and other Sexually Transmitted Infections (STIs) and participate in peer discussions and other information sharing activities. Through the GFATM Round 9 grant to Belize, a comprehensive HFLE programme will be rolled out in secondary schools. The Belize Red Cross, through the Together We Can Peer Education programme on HIV prevention, provides information and education services to young people in schools. The project is being expanded under the current GFATM Round 9 grant to Belize. The Women's Department of the Ministry of Human Development and Social Transformation (MHDST) implements the Gender Awareness Safe School Programme, which includes interactive

sessions on the topics Domestic Violence, Gender Sensitization, Sexual Harassment, Self-Esteem and HIV/AIDS to primary school students at Standard Five level and secondary school students at Second Form level. The objective of this programme is to set a foundation for gender equality amongst boys and girls inside and outside of the school environment.

**Condoms:** Free condoms are distributed through public health clinics, VCT centers, the central prison, and civil society organizations. Free condom distribution was primarily funded through the past and current GFATM grants as well as through the cost-sharing agreement between the MOH and the United Nations Population Fund (UNFPA). The current GFATM Round 9 grant will provide for the free distribution of over 1,150,000 condoms. In addition to this, PASMO/Population Services International-Caribbean and BFLA also focus on social marketing of condoms, supporting the sale of male condoms under the brand names "Vive" and "COOL" including to non-traditional outlets. The NAC initiated the development of a national condom policy with the aim of ensuring universal access to condoms in Belize in all aspects of the market share (commercial, social marketing and free condoms) based on public health principles while ensuring sustainability.

**Testing and Counselling:** VCT services are generally delivered in stand-alone MOH-VCT clinics, which also provide (in some areas) Anti-Retroviral (ARV) treatment. In an effort to scale up, VCT services are also provided by non-MOH agencies including the Belize Central Prison, Loma Luz Hospital the BDF and some BFLA clinics. MOH provides the required testing strips and medical supplies and the agencies in turn supply the epidemiological data to MOH. Additionally, private health care facilities provide HIV testing services which are often not coupled with counselling. MOH introduced the concept of PITC (Provider Initiated Testing and Counselling) in 2009 to further expand prevention efforts by encouraging both private and public health care facilities to make HIV testing accessible during routine medical visits. MOH also implements the "Know Your Status" campaign to encourage testing and counselling. The campaign is being expanded under the current GFATM Round 9 grant to the CCM.

**Prevention of Mother to Child Transmission:** The programme was developed after epidemiological data from MOH revealed that approximately 79% of the HIV transmission in the country was a result of heterosexual contacts. Pregnant women accessing antenatal care are offered voluntary testing for HIV at the time of their first visit and, if negative, are tested again at 32 weeks of the pregnancy. Pregnant women with HIV are referred to the nearest secondary level treatment centre to access treatment and care, including CD4 testing every three months. The current guidelines call for treatment to be initiated in the 14$^{th}$ week of pregnancy and pregnant women can receive diagnosis and treatment at the same facility. The main components of the PMTCT programme include the provision of pre- and post-counselling to all pregnant women who attend antenatal clinics, the screening for exposed children, the provision of milk supplements for babies born to HIV infected

women, and care and treatment for HIV infected pregnant women and their newborns. The desire of the MCH programme to provide quality services to pregnant women who are HIV-positive also resulted in the improvement of the treatment protocol. Since 2006, treatment has moved from the provision of single-dose nevirapine offered during active labour and to their newborns, to the provision of prophylaxis to pregnant women at 14 weeks of gestation. A major aspect of the programme is the integration of a strategy to reduce congenital syphilis into the PMTCT programme. As result of this strategy, there have been no cases of congenital syphilis since 2007. The earlier focus on vertical transmission has been successful and the focus has therefore now shifted towards maintaining and consolidating the low level of vertical transmission.

**Post-Exposure Prophylaxis:** To meet the required standards, the protocol for the administering of Post-Exposure-Prophylaxis (PEP) has been updated in 2010, training of professional health staff has been completed and a non-occupational exposure chapter has been included.

**Facility-Based Diagnosis and Treatment of STIs:** HIV has traditionally been treated and managed separately, instead of being considered as another STI. MOH made the move to manage other STIs under the HIV/AIDS programme which became the National TB, HIV/AIDS, and other STIs Programme, with responsibility for STI prevention, diagnosis and treatment. The country currently manages STIs with a syndromic approach based on the identification of consistent groups of symptoms and easily recognized signs and the provision of treatment that will deal with the majority of organisms responsible for producing a syndrome. With the roll out of the BHIS, the number of facilities reporting epidemiological data on STIs has increased. However there is still a pending agenda in relation to the management of STIs and the linkages with HIV.

**Blood Safety and Universal Precautions:** The Central Medical Laboratory (CML) in Belize City is the only principal public health laboratory in the country. It is also the only facility that conducts confirmatory tests using fourth-generation ELISA on all HIV-positive samples received from all VCT sites and private health facilities. Efforts are being made to ensure that every health region has CD4 testing facilities to reduce the number of samples needing transfer to CML for testing. The CML is also the only major blood bank service in country and is responsible for screening all donated blood. All blood donors are interviewed to assess whether donors engage in high risk behaviours. Blood is screened for HIV-1 and HIV-2 strains, Hepatitis B virus, Syphilis, Chagas disease and Malaria. The UNGASS 2010 reports that 100% of donated blood units were screened for HIV in a quality assured manner. Portions of the CML were destroyed in a fire in 2006, which affected the capacity of the laboratory to effectively carry out its mandate. Laboratory strengthening is an identified need in the country, not only for HIV response purposes, but also in view of the strengthening of the entire health system. The GFATM Round 9 grant has made provisions to provide support to the CML.

## *2.3 Problem Tree Analysis for Ending New HIV Infection*

The main factor in the persistent HIV transmission in Belize is most likely inconsistent condom use in the presence of multiple partners, early sexual initiation and gender-based violence. Across populations, the feature of multiple partners is evident with varying levels of consistent use of condoms with any partner. At the root of unprotected sexual activity are the complex psychological issues that act as determinants sustaining a gap between knowledge and behaviour that prevents the sexual transmission of HIV. Two examples of such determinants are: (1) persons either do not want to know their status or (2) do not want to disclose their status to their partners for fear of rejection, guilt and a perceived reduction of sexual activity. HIV prevalence among vulnerable groups in the population suggests a generalized epidemic with concentrated pockets among some vulnerable groups. The sexual activity of MSM, SW and prisoners could impact the general population and the overall transmission of HIV in Belize. Notably in PASMO's TRaC study, MSM reported having female sex partners, with 21.5% self-identifying as bi-sexual and 4% as hetero-sexual. The need for baseline surveillance and sexual behaviour data as well as a comprehensive strategy for social and behavioural change among such vulnerable populations is evident.

Gender norms and roles in Belize are generally similar to those in Latin America and the Caribbean and impact sexual practices and risk behaviour of both men and women. Machismo and socio-cultural norms validate and reinforce the expectation that men have multiple sexual partners and provide a sense of infallibility as it relates to health and sexual health in particular. This often leads to limited participation of males in health services, particularly SRH services which may contribute to men's self-denial of their HIV status. This is evident by the significantly lower testing rates among men, compared to women.

Evidence indicates that some persons, particularly women, young persons and sexual minorities, are often not in control of with whom and under what circumstances they have sex. The higher HIV prevalence rates of young women and girls, when compared to their male peers of the same age group, as well as the high prevalence rates of men aged 35-49 when compared to their peers of the same age group is an indicator of the presence of intergenerational sex, often characterized by coercion, force, or in exchange for economic gain. This also contributes to the early sexual initiation of girls and boys.

Policy and legislative barriers restrict the access of young persons to a comprehensive package of sexual and reproductive health services, particularly the ability to access health services without the consent of a parent or guardian. There is discordance between the age of sexual consent and the

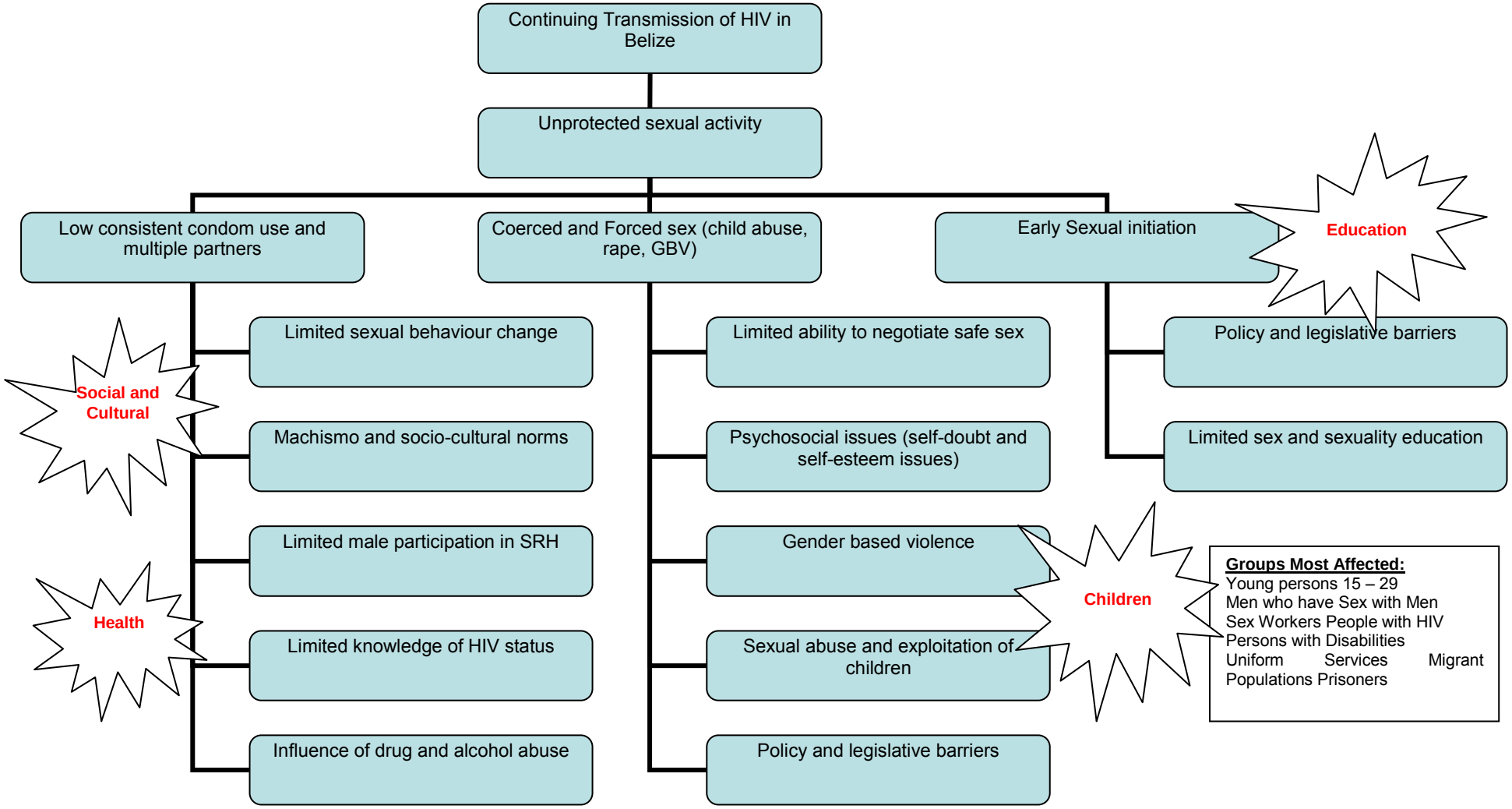
age at which young persons are able to access health services on their own. Despite lower testing numbers among young women when compared to older women, the HIV prevalence rate is significant, indicating that critical attention needs to be placed on this group.

There are groups that are most in need of prevention services:

1. **Young people, particularly adolescent girls, and young persons who are MSM, SW, and prisoners.** Anecdotal evidence indicates that with the expansion of the tourism sector in Belize, the incidence of young FSW has also increased. Young people are also very vulnerable to coerced sex, either through sexual violence and rape but also through commercial sexual exploitation, particularly adolescent girls. The new infection trends indicate that generational mixing of young women, 15-24 years of age, and adult males, 35-49 years of age, is a salient feature in the epidemic. Of particular concern are young women and girls, as the number of HIV infections is consistently higher among young women, 15-24 years, than young men in that age group. HIV vulnerabilities for women are related to three major gender issues: 1) Unequal gender and power relations between men and women and boys and girls; 2) Gender-based violence which is driven by unequal gender and power relations; and 3) Unprotected sexual activity resulting from lack of adequate information, lack of access to commodities, lack of proper use of commodities and low HIV risk perception or impaired judgment.
2. **Adult Men (including MSM):** Social norms that validate risky sexual behaviour among men, coupled with their poor health-seeking behaviour, increase their vulnerability to HIV infection. The mixing of adult men and young girls also impacts the sexual transmission of HIV within the wider population. The MSM population still remains relatively invisible to the health care system, making it difficult to adequately plan, expand and distribute services that meet their needs. MSM continue to be reluctant to disclose their sexual orientation when accessing services. Bi-sexual men including those, who are sex workers and have sex with males and females, constitute a factor that contributes to the HIV transmission profile and that needs more investigation to improve the effectiveness of the HIV response in Belize.
3. **Sex workers and their partners:** Clients of FSW come from the general population; FSW report low condom use with their affective partners and inconsistent condom use with clients. It is theorized that some male sex workers have both male and female clients. The evidence presented indicates that sexual activity among vulnerable groups, and between these groups and the general population is significantly contributing to the persistent HIV transmission in Belize, and that the national response needs to focus on these populations through targeted high impact prevention interventions and increased access to SRH services within an enabling policy environment.

4. **Prisoners:** Upon re-entering society, the vast majority of prisoners are lost by the prison-based health system and often do not seek healthcare from other sources. Due to high prevalence of behaviours conducive to the transmission of HIV and other STIs, the prison may be viewed as a reservoir of HIV amplification and its subsequent spreading within the general population. These behaviours predominantly include unprotected sexual activity and forced sex in an environment of restricted access to condoms and sexual health education, as well as reduced ability of partners to negotiate safe sex in an atmosphere characterized by violence, fear and shame.
5. **Mobile and Migrant Populations:** Mobile populations are vulnerable because their most fundamental rights are very often denied in their country of origin, the transit countries and the country of final destination. Those in authority at the borders often demand cash from people attempting to cross illegally and often women are forced to exchange sex in lieu of or in addition to cash when attempting to cross the border. In this environment, transactional sex, survival sex and non-consensual sex are carried out in conditions that place individuals at risk of HIV infection; condom use is infrequent.
6. **Uniformed Services:** The uniformed services, especially senior men and women, are highly vulnerable to HIV infection because of their work environment, mobility, age and other factors that expose them to higher risk of infection than their civilian counterparts. Men make up the vast majority of personnel in most uniformed services around in Belize. Young men between the ages of 15 and 24, who are either not married or who are stationed far from their regular partners or families, are the largest and most vulnerable group. Like their civilian counterparts, they are the most likely to become infected with HIV and to infect others. The fact that they are often away from home makes them more likely to use sex workers, become infected with STIs (including HIV) and, in turn, infect their spouse, girlfriend or casual partners when demobilized or on leave.
7. **Persons with Disability:** Anecdotal evidence reveals that there are limited national initiatives providing for the SRH needs of persons with disability. Often this is being fuelled by the false assumption that persons with disability do not have sexual desires and needs. Access to service is even more challenging for this population as most of the buildings are not easily accessible or service providers are unable to communicate with the differently able.

**Chart 1: Problem Tree Analysis for Ending New HIV Infection**



## *2.4 The Remaining Gaps and Challenges*

1. **Evidence Building and Strategic Information in an effort to know your epidemic.** More needs to be done to fill the remaining significant information gaps in Belize. There is limited understanding of the modes of transmission and the levels of infection among certain groups in the population. Second generation surveillance, particularly among young people, MSM, SW, and prisoners, as well as studies to provide empirical evidence of the incidence and impact of gender-based violence and HIV transmission need to be conducted and analysed to substantiate the strategies being employed to end HIV in Belize. This should also include prevention strategies for persons with HIV, which incorporate positive health, dignity, prevention and treatment as prevention. Additionally, economic and social norms and practices that cause barriers to HIV prevention need to be studied in order to effectively plan for a prevention revolution. The national monitoring and evaluation system needs to be improved to adequately allow for the assessment of the effectiveness of the prevention programmes being implemented, including annual reporting against outcomes and outputs, as laid out in the prevention strategy.

2. **Comprehensive Information, Education and Communication (IEC) for social and behaviour change strategy including targeted social and behaviour change interventions among young people, FSW, MSM and Prisoners:** Sexual activity is thought to be the main mode of transmission of HIV in Belize, with a particular focus remaining on MSM, SWs, young women, prisoners and migrant populations. There is a lack of significant demonstrable change in attitudes and sexual behaviour among these vulnerable groups, which signals an insufficient translation of knowledge into sustained sexual behaviour change. In-depth evaluation of the effectiveness of current prevention communication interventions and intensive research to guide future IEC-BCC strategies and interventions are needed. Communication-based prevention programmes need to focus on risk-perception, attitudes, skills development and ultimately behaviour change and not only on knowledge; behavioural change strategies need to challenge cultural norms that encourage acceptance of multiple partners, early sexual debut, gender inequalities, as well as highlight the impact of alcohol/illegal substances on risky sexual behaviour, and promote condom use. One important tool to increase positive behaviour change that can be used is the development of a unique plan of protection for each individual – which he or she develops taking into consideration his or her character strengths and weaknesses, vulnerabilities and support systems. These plans are referred to as Personal Protection Plans and are designed to bridge the gap between knowledge and behaviour because they are rooted in the realistic assessment of each person's preparedness and likelihood of positive behaviour change.

3. **Comprehensive and effective clinical management of other STIs:** Both ulcerative and non-ulcerative STIs have been found to increase the risk of sexual transmission of HIV, which makes STI control important in HIV prevention. Efforts to implement case-based management, including standardized treatment of STIs, need to be stepped up. The training of physicians and the education of the public on the proper management of STIs are important strategies in controlling STIs. Equally important is the assessment of the levels of antimicrobial resistance in the country and its impact on the STI management.
4. **Limited number of persons knowing their status:** Low levels of voluntary testing and counselling persist in the general population, which warrants the expansion of current PITC efforts to target PITC to identified vulnerable populations. Positive Health Dignity Prevention with persons with HIV is a prevention intervention that needs development in Belize. The response to HIV within the work place, especially in the agricultural and tourism sectors, needs strengthening. The availability and access to PEP requires concrete expansion for occupational and non-occupational exposure. Other areas of future work need to include: improved access to comprehensive sex and sexuality education for children, adolescents and young adults, both in and out of school; removal of laws and policies that inhibit certain groups and populations from accessing SRH services and commodities; the scale up of programmes that address stigma and discrimination, violence, and criminalization; as well as, the expansion of IEC/ BCC programmes to reach prisoners and migrant populations.

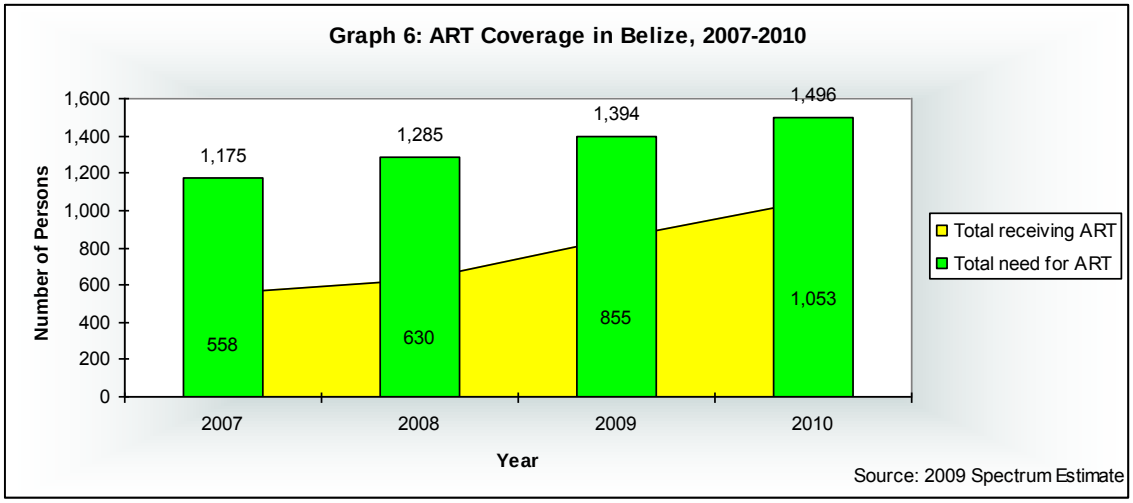
# Chapter 3 Improving Health and Wellbeing

## *3.1 The Situation*

**Antiretroviral (ARV) treatment**

The Government of Belize (GOB) initiated the programme to provide free ARVs to persons with HIV, in accordance with national treatment guidelines established in 2003. By 2005, the programme was providing free Antiretroviral Therapy (ART) to almost 300 persons. Since the initiation of the ARV scheme, the national programme has demonstrated a significant uptake in placing new patients on ARV treatment. In 2010, MOH had thirteen (13) regiments ARV regiments in Belize, eleven (11) adult and two (2) paediatric, to over a thousand patients. Since 2003 the treatment guidelines have not been updated and as a consequence MOH has opted to use the Caribbean Guidelines for the Care and Treatment of Persons with HIV Infection, developed by the CAREC/PAHO and Caribbean HIV/AIDS Regional Training Network (CHART). In an effort to improve quality of life outcomes GOB has recently embarked on an initiative to update the existing treatment guidelines, with the aim of improving efficiencies in treatment regiments as well as moving the threshold for treatment eligibility from CD4 <350 to CD4 <500. The new guidelines will inform the initiation of ART, the initial regimen chosen, adherence, treatment preparedness, patient monitoring (including for treatment failure, second line regimen, as well as salvage treatment), treatment for OIs (including TB and hepatitis co-infection) and other HIV co-morbidities. It is expected that when the new national guidelines are applied, the number of HIV positive persons receiving ART will be significantly higher. The programme also continues to expand its therapeutic options and has started acquiring newer fixed dose combinations to enhance adherence to treatment.

**Persons on ARV Treatment**




Spectrum-EPP calculates the estimated number of persons in need of treatment on basis of parameters and data from national programme monitoring and a CD4 threshold of 350. Based on the estimated number of persons in Belize in need to ART, the ART coverage has grown from 47.5%

in 2007 to 70.4% in 2010[23]. While the number of newly reported HIV infections shows a downward trend, the number of persons in need and entering ARV therapy is expected to increase exponentially until the prevalence of HIV plateaus and begins to decrease in the country. The coverage rates for females have been consistently higher than that of males. In 2010, 335 persons initiated ARV therapy, to give a total of 1,053 on ART. The coverage of children with HIV is optimal and almost 70% of adults needing treatment are covered. It must be noted that MOH also uses the patients' monitoring and history, e.g. patients showing rapidly declining CD4 numbers, as trigger to start ARV treatment. The high coverage numbers in children may also indicate under-estimation and/or under-counting of children with HIV over the years. With improvements in the monitoring systems, due to the roll out of the BHIS, these inconsistencies are expected to diminish.

**Table 4: ART Coverage for 2008 - 2010**

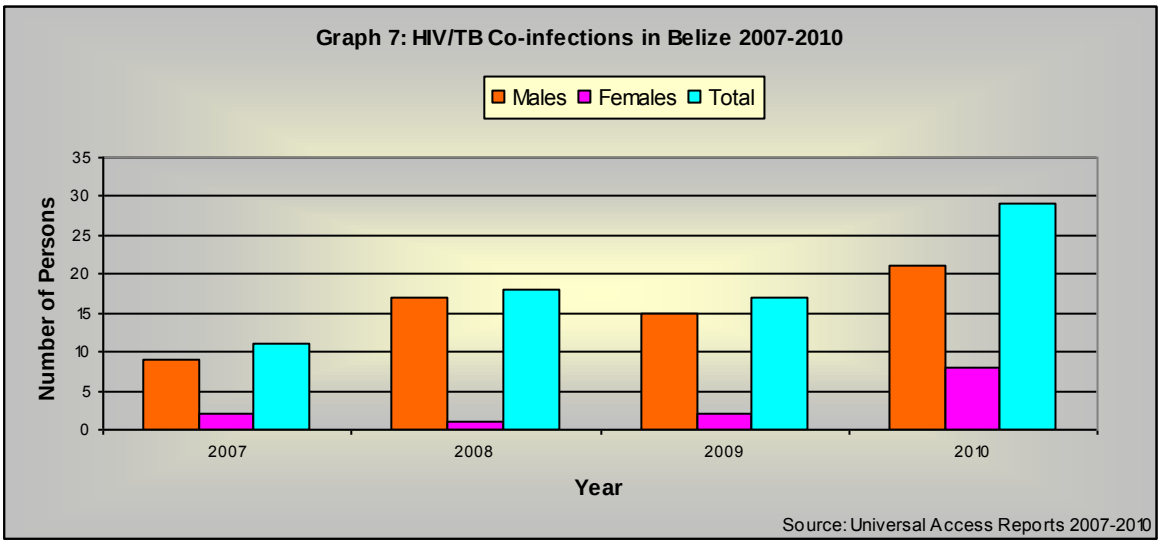
| | | Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy | Estimated number of adults and children with advanced HIV infection | Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (Percent) |
|---|---|---|---|---|
| **2008** | **All** | 630 | 1,285 | 49.0% |
| | **Males** | 307 | 653 | 47.0% |
| | **Females** | 323 | 632 | 51.1% |
| | **<15** | 64 | 78 | 82.1% |
| | **15+** | 566 | 1,207 | 46.9% |
| **2009** | **All** | 855 | 1,394 | 61.3% |
| | **Males** | 444 | 708 | 62.7% |
| | **Females** | 411 | 686 | 59.9% |
| | **<15** | 80 | 87 | 92.0% |
| | **15+** | 775 | 1,307 | 59.3% |
| **2010** | **All** | 1,053 | 1,496 | 70.4% |
| | **Males** | 523 | 760 | 68.8% |
| | **Females** | 530 | 736 | 72.0% |
| | **<15** | 105 | 94 | 111.7% |
| | **15+** | 948 | 1,402 | 67.6% |
| Source: Belize 2010 UNGASS Report, 2010 Universal Access Report, 2009 Spectrum Estimates and MOH Annual Report | | | | |

[23] NAP Annual Reports, Belize 2007-2010 and 2009 Spectrum Estimates

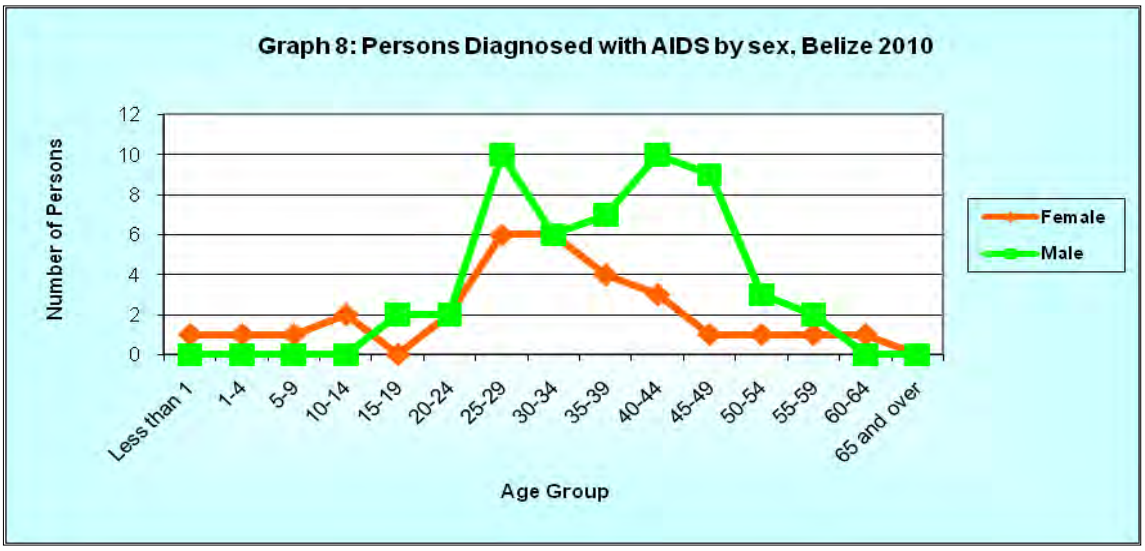
The continued trend of improvement of this Universal Access indicator indicates that ART coverage in Belize is relatively high. However, new investments will become necessary to counteract increased drug-resistance and to provide follow up to the scientific evidence that early initiation of ART has the potential to reduce viral loads and, therefore, transmission rates.

**AIDS-Related Illness and AIDS-Related Deaths[24]**

In 2010, there was a slight increase in documented cases of HIV/TB co-infection, which may have resulted from more active case finding of tuberculosis cases in persons with HIV. The number of HIV/TB co-infections among males is significantly higher than females.

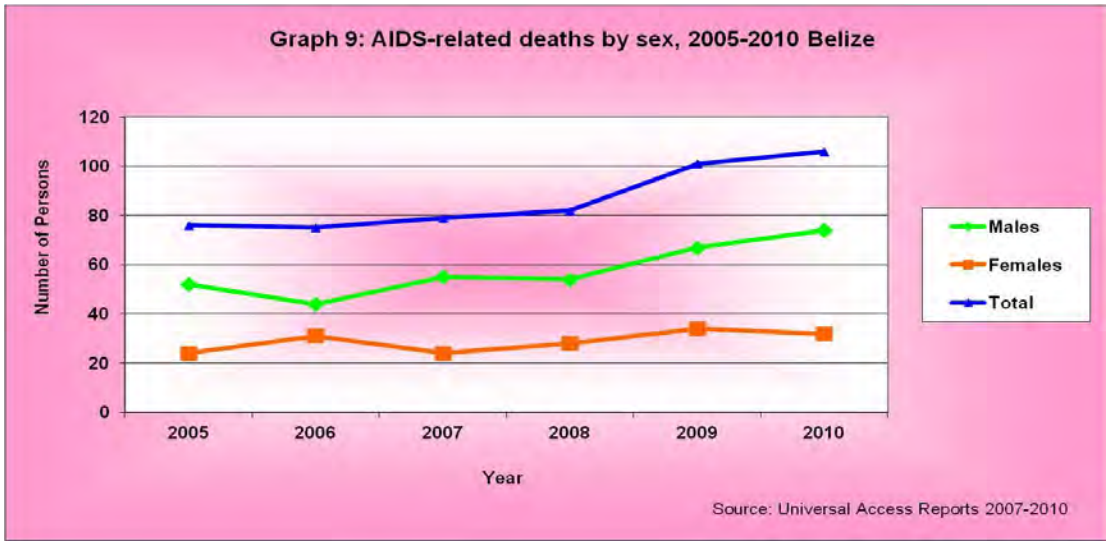



Ninety percent of antenatal clinic attendees are tested for syphilis with a stable prevalence of around 1% per annum, which coincides with the HIV prevalence among pregnant women. There is limited data published on the incidence and prevalence of opportunistic infections in people with HIV in Belize.




[24] National TB, HIV and other STIs Programme; Annual report 2010; Ministry of Health

In 2010, a total of 81 persons were diagnosed with AIDS, of whom 51 where males. MOH reports a fluctuating pattern in the number of reported AIDS cases, reflecting the difficulty in tracking people with HIV infections lost to the health system after diagnosis and who only re-enter the system at later stages of the progression of the virus. This is particularly so for the male adult population. The majority of the newly reported AIDS cases are in the age group 25-49 years, with males more frequently detected than females (see Graph 8). This could be attributed to poor health-seeking behaviour of males, as they often report to the health care system in advanced stages of the disease. Similarly, AIDS-related deaths occur more frequently in males than females. In 2010, males, who died from AIDS-related illnesses, accounted for more than double the number of females, of which the majority of deaths occur in the 25-49 years age group.




In spite of the availability of free ART in Belize and a reported survival rate, twelve months after initiation of ARV, of 75.6% in 2009, AIDS-related deaths continue to increase, particularly among men. In 2009, the 12 month-survival rate on treatment was estimate for the first time at 75.6%[25], which does not meet the minimum international standard of 90%. Simply put almost 25% of persons initiating ART either died or were lost to follow-up within 12 months of initiating treatment. It is expected that this indicator would improve with the rapid scale-up of treatment and the expansion of adherence programmes. In 2010, the 24 month-survival rate on treatment was estimate for the first time at 90.8%[26], which is significantly higher than the 12-month survival rate. This provides a clear indication that adherence to treatment improves health outcomes and survival rates. More studies on adherence and resistance to treatment in Belize are needed to optimize treatment outcomes.

[25] 2010 UNGASS report: Belize
[26] 2011 Universal Access Report: Belize

**Care and Support Services**

One imperative that requires strengthening in the health sector response to HIV in Belize is that the comprehensive care of persons with HIV complements the provision of ART. This includes early HIV diagnosis, early enrolment into care with regular CD4-count monitoring to determine eligibility for ART, and the initiation of ART before sickness occurs. But it also includes the psychosocial support needed to cope with the life changing events following an HIV diagnosis. Belize has expanded HIV testing and counselling to include a PITC approach in addition to client-initiated testing and counselling (CITC); however this is still not fully integrated into the primary health care system with only 61% of all health care facilities providing T&C services[27]. Provision of STI services for persons with HIV continues to be inconsistent and patients often opted for self-diagnosis and treatment. Thirteen of the 108 health care facilities provide ART treatment, patient follow-up using CD4 counts and use WHO clinical stage guidelines as a benchmark for initiating treatment. Viral load testing is not done in-country and patients are generally recommended for viral load testing by the doctor based on clinical observation. The services of a private lab outside of the country are used for viral load testing and because of the costs, only a limited number of patients receive viral load testing each year. Viral load tests are also donated to the country by organisations such as PAHO/WHO and the Mesoamerican Project. Additionally, the GFATM Round 9 grant to CCM will provide viral load tests for 600 patients over the next two years. The Early Warning Indicators are currently being used to monitor resistance to ARV drugs in Belize.

## *3.2 The Response: Treatment, Care and Support*

**HIV Treatment:** By the end of 2009, there were 11 treatment sites in Belize, two in each of the Southern, Northern and Western Health regions and six in the Central Health region, of which one is managed by a faith-based organization (Hand in Hand Ministries), another by the medical unit at the Belize Central Prison (Kolbe Foundation), and one by the BDF at its BDF-Clinic since 2010. GOB provides free ART to persons with HIV, who are eligible for treatment according to national treatment guidelines. MOH utilizes the clinical staging, as established by the WHO criteria, for starting ART and/or a CD4 count of 350 or lower. Currently, MOH is updating its treatment guidelines to move this threshold to 500. In addition to free ARV treatment offered, MOH also provides medications for most opportunistic infections at no cost to the patient.[28] Infants exposed to HIV receive Zidovudine and Trimethoprim/ Sulfamethoxazole for the first six weeks after birth. Dried Blood Spots (DBS) specimens are prepared and sent to Honduras for PCR testing at 48-72 hours, 6 weeks and 12 weeks after birth. MOH also provides free replacement feeding for the first 10 months for children born to HIV- positive mothers. Pediatric HIV cases are seen at MCH clinics for the first 18 months, after which they are referred to paediatricians in the hospital for clinical

[27] 2011 Universal Access Report: Belize
[28] UNGASS Country Report, 2010

management and to the VCT for ARVs. Belize will have established by the end of September 2011 the protocol for managing pediatric HIV cases. Additionally, second-line ARVs are only available for pediatric cases, with a total of 15 children on second-line treatment at the end of 2010. ARVs are also now distributed through some of the public health care pharmacies.

**Clinical Management and Monitoring:** This is a main area of work of the National HIV, TB and other STIs Programme of MOH. Although the number of persons receiving ARVs in Belize has increased significantly in the last two years, a more pro-active approach to patient case management will need to be employed to achieve the Universal Access Goals by 2015. MOH routinely receives external funding from other donor agencies to cover the cost of viral load testing; however this is sporadic and inconsistent. The recent roll out of the HIV module of the Belize Health Information System in 2009, which includes an electronic patient record, is expected to significantly impact patient tracking and clinical management.

**TB/HIV Collaborative Activities:** The country routinely screens all TB patients for HIV; however not all HIV patients are screened for TB, unless they appear symptomatic. As in the case with ARV therapy, the medications for TB are provided free of cost to all patients identified. In an effort to further address this co-infection issue, the TB programme is now managed jointly with HIV and efforts are currently underway for further integration in all programmatic aspects of both programmes.

**Procurement and Supplies Management (PSM)[29]:** This has been identified as a critical issue within the Ministry of Health. In 2006, government's expenditure on drugs and medical supplies amounted to US$3.75 million. A total of 187 items were procured to cover needs for up to twenty (20) months. A rapid assessment of the public sector conducted in the same year revealed major weaknesses in PSM. These included the absence of reliable method for quantifying orders; an analysis of the 2006 procurement exercise showed that 50 percent of items were under-ordered, 29% were over-ordered and in only 21% was the order quantity correct; inconsistent use of a transparent procurement process; inadequate storage facility; weak inventory management process; parallel procurement, distribution and accounting for ARVs; inadequate facilities for transportation; personnel shortages at Central Medical Stores (CMS) and regional stores. An electronic order system came on stream in August 2008, facilitated by the BHIS. It confers the advantage of speed, accurate documentation and greater efficiency. Under this arrangement, holding costs are low since the CMS needs to stock only limited quantities of drugs and supplies. Storage requirement at health facility level is also reduced and incidence of stock-out is less likely to occur as the electronic order system will generate alerts when pre-set thresholds are reached. Although these improvements have been anticipated and

[29] Global Fund Round 9 Proposal: Accelerating the Pace: Reaching Marginalized and Vulnerable Populations with Critical Services, Belize 2009

have started to roll out in many instances, there is still sufficient evidence of stock outs of ARVs, free condoms and testing kits across the country to warrant a comprehensive review of the existing procurement and supplies chain management and scaling up of the systems and human resources necessary to realize the intended benefits of PSM.

**Care and Support Services**: Currently, there is no framework to provide a comprehensive package of services for persons infected and affected by HIV, including psychosocial and socioeconomic support or legal aid. Psychiatric nurse practitioners at the VCT centres provide limited counselling services and persons needing long term counselling are referred to the Psychiatric Clinics in each district. The Ministry of Human Development and Social Transformation (MHDST), provides a social safety net for those most in need, including persons with HIV. Currently, MHDST has embarked on developing a Single Information System of Beneficiaries (SISB) for Belize that would better coordinate the social protection system in Belize. This will include HIV as a poverty vulnerability factor. There are some civil society organisations providing counselling services and community support, however this is not consistent or coordinated, as most of the work is dependent on volunteers and external funding support. The Caring for Children Protection and Support Network was set up to provide outreach and institution-based support programmes for children infected and affected by HIV in three districts. Civil society organizations provide food, clothing, and supplies for HIV-infected school children and children of persons with HIV, income generating initiatives and job placement for persons with HIV. There is a special fund to render financial support for urgent medical needs of persons with HIV. The GFATM Round 9 grant aims to train professionals and community leaders in two districts in basic counselling skills for the provision of psychosocial support to persons with HIV and their families. People with HIV have formed The Collaborative Network of People Living with HIV and now manages a Regional Global Fund Grant which provides education, empowerment training and watch dog functions on the national response.

## *3.3 Problem Tree Analysis for Improving Health*

The main causes of ill health and premature death in people with HIV are delayed initiation of treatment and/or treatment failure in the presence of late HIV diagnosis, stigma and discrimination, poor health seeking behaviours, non-adherence to or poor quality of treatment, opportunistic infections and health system challenges.

**Sense of Wellbeing and Acceptance of HIV Diagnosis:** The health and wellbeing of people with HIV is closely linked to their diet, nutritional options, lifestyle (pre- and post diagnosis), social situation, emotional and psychological states. Persons diagnosed with HIV often feel a loss of dignity and shame which can propel them into self-exclusion from family, friends and the health care system. Often this self-exclusion also comes with self-denial and self-stigma, which impact the spread of HIV. The level to which this happens is highly dependent on the support mechanisms surrounding people

with HIV. Detrimental attitudes of health care workers significantly impact whether an individual continues to access the much needed care and support.

**Accessing HIV Treatment, Care and Support Services:** Studies have shown that service providers have detrimental attitudes to persons with HIV, which may hinder the achievement of universal access to prevention, treatment, care and support services. With a large portion of the population not knowing their HIV status, this also impacts on the prevention efforts to stop transmission. Linking treatment and prevention remains important in ending HIV in Belize. A KAP study conducted among uniformed service officers of the BDF indicated limited knowledge about treatment for HIV[30]. Additionally, the basic indicator report of MOH indicated that the number of men accessing health care services is significantly lower than that for women. It is theorized that social and cultural norms portray men as dominant and strong, while associating men who seek health services with weakness.

**Survival on ART:** There is limited collection and publishing of national HIV drug resistance data required to inform national policies that will curb consequences of drug resistance. Additionally, weaknesses in laboratory capacity including the determination of CD4 cell counts, viral load and the diagnosis of opportunistic infections, caused mainly by poor laboratory infrastructure and human resource shortages, remain major issues for the health systems strengthening in Belize. The absence of national viral load and HIV drug resistance testing in Belize significantly hampers the progress in managing toxicities and treatment outcomes. This becomes even more imperative as discussions are on the way to place persons on treatment even earlier, which would result in people being on treatment for longer periods of time.

**National Social Protection Networks:** The majority of persons with HIV are adults in the peak of their productivity and earnings. Despite increasing access to treatment, it is recognized that the socioeconomic impact of HIV can push households into poverty, either through lost of earnings brought on by failing health or premature death, increased medical bills, or through exclusion brought on by stigma and discrimination. It is also recognized that poverty is one of the determinants of vulnerability to HIV and many of those getting infected come from marginalized, poor realities. Therefore an imperative of the national response in Belize is ensuring that people with HIV are able to access the national protection system that contributes to their overall health and wellbeing.

Currently, Belize is building an HIV-sensitive single information system of beneficiaries that will enhance the social protection of persons with HIV. However, the civil registration under this database is still limited in its scope and currently those most vulnerable to the debilitating effects of

[30] A Serological and Behavioral Assessment of HIV Infection in the Belize Defense Force

HIV/AIDS are not being registered. The Ministry of Human Development and Social Transformation currently implements three poverty alleviation programs that offer some support for PWHIV in need. These are the Boost Program which provides conditional cash transfer for parents with children who remain in school, The Pantry Program which offers basic groceries for reduced prices and the Community Rehabilitation Department which provides several types of psycho-social support. The vulnerabilities related to marginalization, poverty and HIV also lead to further high risk behaviour, including sex work, domestic and gender based violence as well as non-adherence to treatment, which impact HIV transmission in the long run. The further coordination of the national response to HIV in respect of social protection of persons with HIV and their families is imperative if the country is to mitigate the vulnerabilities that AIDS places on the family and to end the further transmission of HIV. The continued mainstreaming of HIV/AIDS into existing social protection strategies and plans is therefore of utmost importance if the state is to mitigate the socioeconomic impact that fuels the epidemic.

**Private Sector Partnerships:** Although very relevant to the national response, the existence of the Private Sector Coalition on HIV in Belize has a limited impact on the poor and provides minimal social protection. The private sector programmes are mainly geared towards established organisations, often established members of the national business groupings. More work needs to be done to engage the private sector and to ensure that programmes are far reaching and include rural communities and informal “grey economy” sectors, most vulnerable to the impoverishing effects of HIV/AIDS.

**Chart 2: Problem Tree Analysis for Improving Health and Wellbeing of People with HIV (Part 1)**

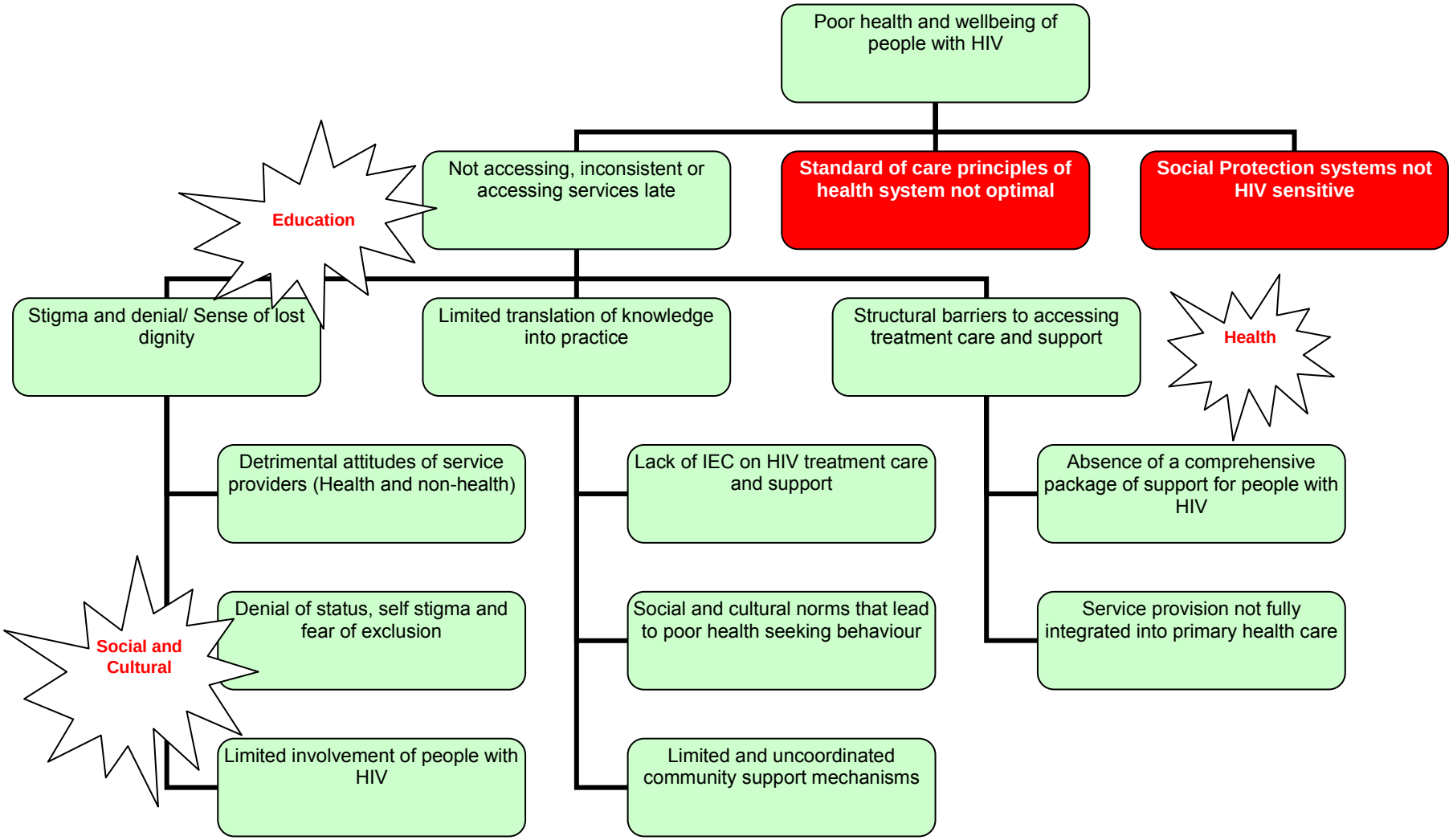


**Chart 3: Problem Tree Analysis for Improving Health and Wellbeing of People with HIV (Part 2)**

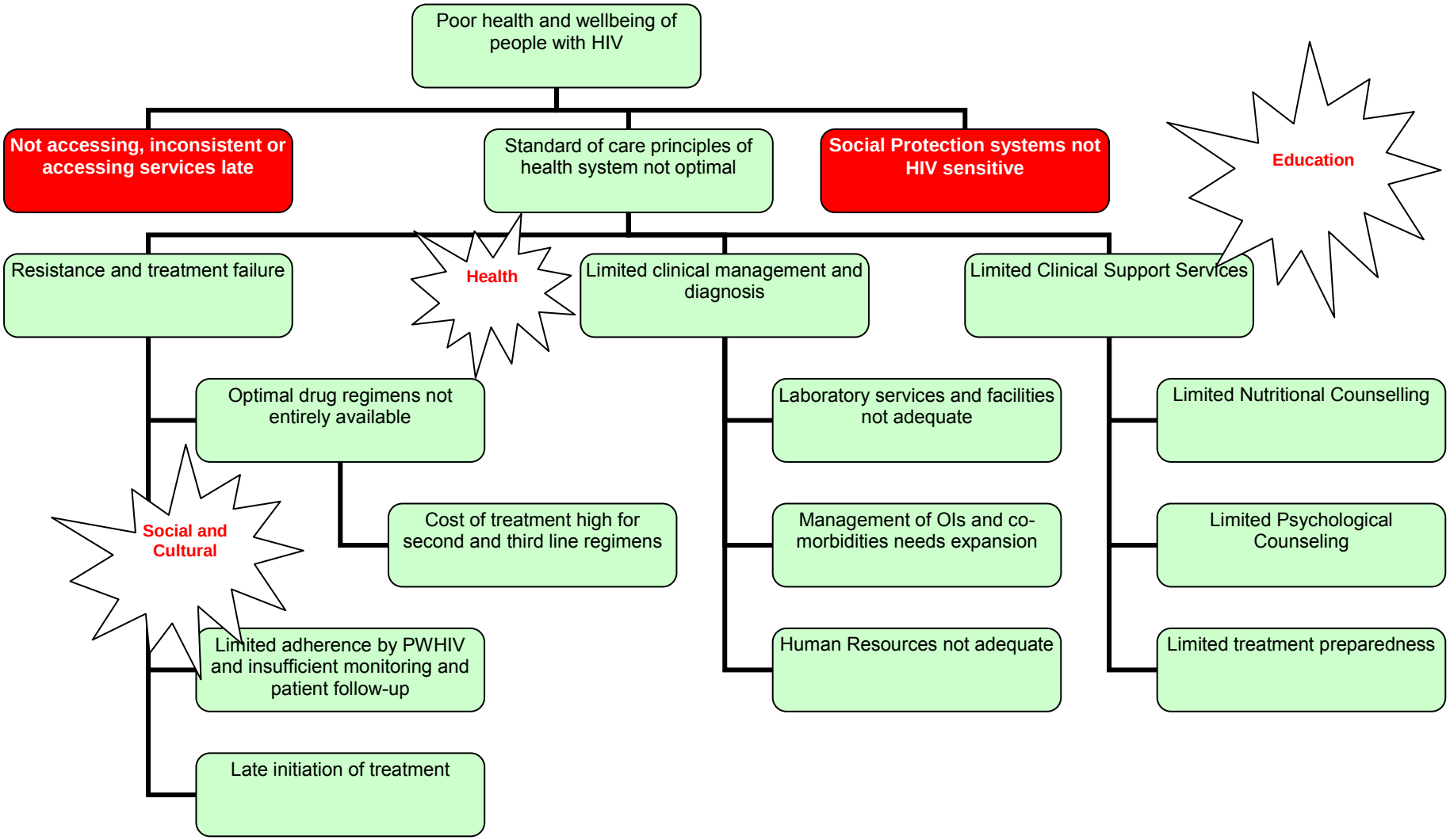
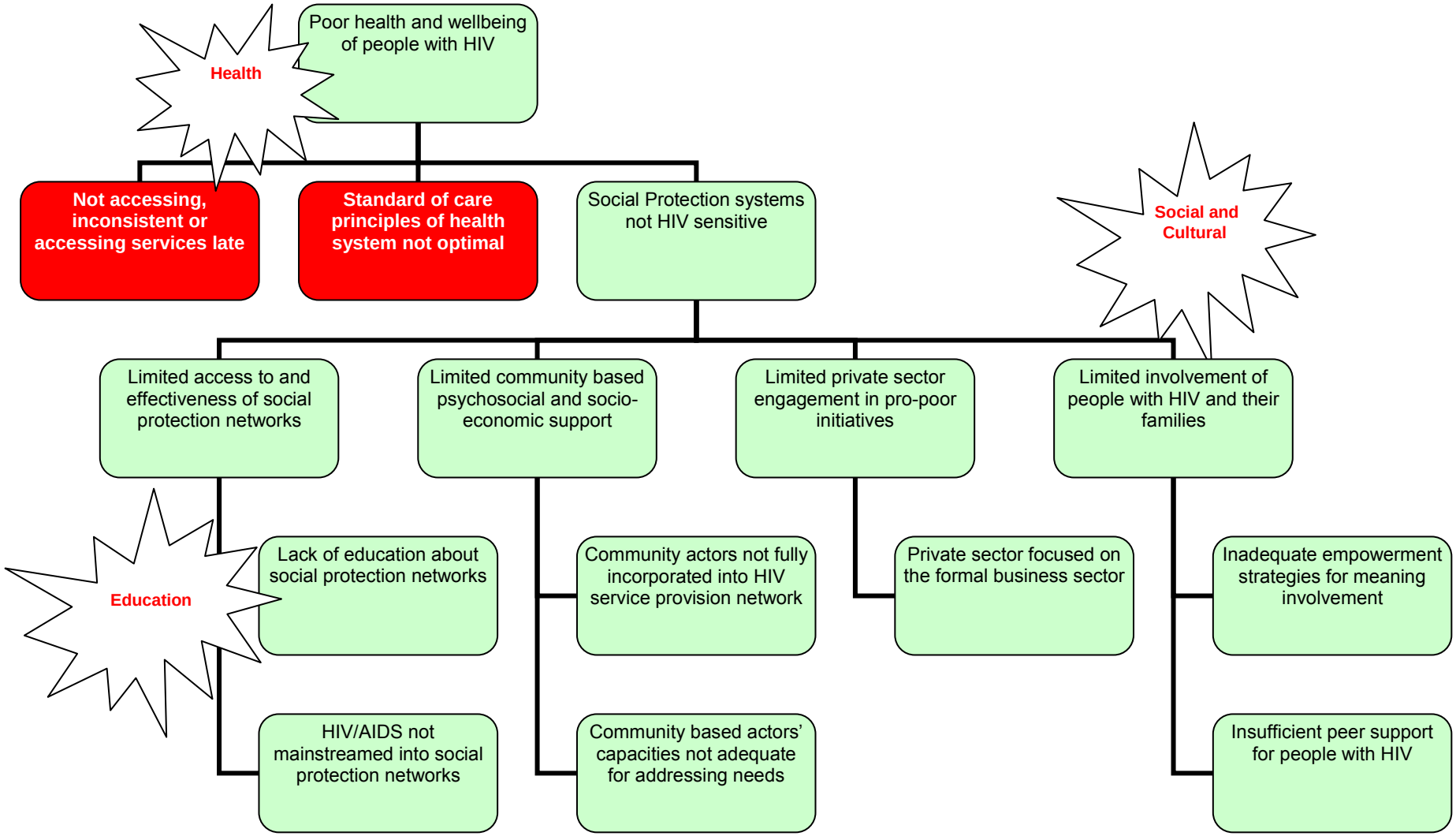


**Chart 4: Problem Tree Analysis for Improving Health and Wellbeing of People with HIV (Part 3)**



## *3.4 The Remaining Gaps and Needs*

**Provision of HIV treatment:** A proportion of persons in need of ART are still not accessing treatment. Agreements between public and private health care providers need to be strengthened for the provision of clinical care and treatment for persons with HIV, who prefer to access services from private providers. Belize is a lower middle income country and the cost of treating persons with HIV with optimal drugs is high. Ways of making improved drug regimens widely available as well as reducing AIDS-related morbidity must be examined to reduce the cost of treatment and allow for the expansion of treatment into more optimal care and treatment. Strengthening adherence mechanisms and improving patient monitoring on ART, including those who have been released from prison, will also impact AIDS-related illness and deaths. To fulfil the human right to good health of all persons with HIV and to create additional incentives for the reduction of HIV transmission, it is crucial to increase and expand the antiretroviral treatment and clinical management of persons with HIV. This will require the continuation of the expansion of ART with the availability of optimized drugs, with minimal toxicities, higher resistance thresholds, limited drug interactions and side effects, as well as easier-to-use therapies. Decentralization and integration of HIV and SRH services need to overcome barriers in order to improve access to ART and to improve the quality and sustainability of the service delivery.

**Information, Education and Communication:** The social protection network needs to include health and educational aspects and not only the economic assistance. The lack of knowledge about the safety nets that are available under the social protection systems of a country is primarily linked to lack of education about social networks. Education is also a cross-cutting theme through all aspects of the response to HIV. Education on treatment options and coping with an HIV diagnosis is important in empowering persons with HIV to actively participate in their own health outcomes and will also have a positive impact of risk reduction and reducing the spread of HIV.

**Clinical Management:** There is significant room for improvement in the diagnosis and management of HIV infection, AIDS and opportunistic infections (OIs) , including the provision of CD4 testing at every care access point, the provision of in-country viral load testing, as well as systematic and routine testing for related conditions. Significant investments have to be made in the areas of cost-reduction and financial sustainability of treatment plans for HIV and related conditions, particularly tuberculosis and other OIs as well as other STIs that increase vulnerability to HIV. One of the main set-backs in improving HIV diagnosis in Belize is the challenging gap in infrastructure and in-country human resource capacity for laboratory diagnosis, particularly as it relates to viral load testing. Communities of people with and vulnerable to HIV need to find avenues to advocate for improvements in the provision of clinical care and treatment, including the provision of optimal drugs, routine monitoring and diagnosis of related conditions, nutritional counselling and support, as

well as the understanding of their own health condition. Improvement in the monitoring and analysis of TB/ HIV co-infections and TB-related deaths among people with HIV is needed. The implementation of the HIV/ TB collaborative activities to reduce the burden of HIV and TB in persons with HIV is essential for Belize, and this should include treatment of HIV and TB regardless of the CD4 count. It is expected that the number of AIDS-related deaths is likely to increase if no additional comprehensive interventions are made that put the client at the centre of care while streamlining and integrating the delivery of services.

**Integration of Services:** Full integration of treatment, care and support services is an important factor to address the negative influence of stigma and discrimination on the consistency of delivery and uptake of services for persons with or vulnerable to HIV. In a resource-constrained setting and in order to achieve a sustained scale up of HIV prevention, treatment, care and support services, Belize must consider an integrated approach to decentralization within primary health care. Belize has taken steps in this direction with the integrated maternal and child health services (MCH services are not integrated). Using this best practice, the integration of other services such as HIV and other STIs, TB and malaria would undoubtedly increase access and coverage for health services for the full life cycle. The integration of services in Belize continues to be a slow process particularly as the physical infrastructures preferences vertical services.

**Support Services:** Persons with HIV face significant barriers to accessing HIV care, treatment and support services, including HIV-sensitive social protection networks, assistance with managing stigma and discrimination, as well as financial and emotional support. There is a need for the integration of HIV sensitive support services into the national social protection networks, which is expected to provide social safety nets, particularly for women who are often the primary care givers in families affected by HIV. Targeted beneficiary indices currently being developed in-country should be adjusted to account for the socio-economic impact of HIV on households. Multi-sector care and support systems need improvement, including the development and implementation of an effective care and support referral network for persons with HIV; including psycho-social support, nutrition support, home-based palliative care, housing and income generation programmes to support adherence and enhance the quality of life. Persons with HIV need to be better informed and educated about their health situation via peer support, counselling and tailored intervention programmes, including Prevention with Positives. These support services are to be decentralized to the community level and should to include access to the basic packages of support services at the local levels.

**Procurement and Supplies Management (PSM):** The Ministry of Health has a procurement and supplies management protocol which is linked to the BHIS and keeps track of all movement of ARVs from their importation into the country to their shipment to the national storage facility and their

distribution around the country. There is anecdotal evidence, however, that key players in the Ministry's staff are not sufficiently familiar with the protocol or are not following it. An assessment of this entire protocol including the human capacity and resources that implement it is overdue. In addition, there is much confusion surrounding the caretaking and access to rape kits. Many doctors in the public health system are not familiar with the post sexual violence protocol and shy away from using the rape kits. Furthermore, the rape kits are distributed by the police and are not always available on weekends or at night. While some health facilities now carry the rape kits, they are not consistently available. This system is obviously not working and needs to be addressed as a priority. Any such assessment should include a review of procurement and supply of other valuable commodities such as free condoms, rape kits and testing kits for private health clinics managed by civil society partners. In addition, there is a need for greater coordination of responsibilities and response protocols for sexual violence between the Police and Health Departments.

# Chapter 4 Creating an Enabling Environment

## *4.1 The History of the National Response in Belize*

The first case of HIV in Belize was diagnosed in 1986. In 1987, MOH established the National AIDS Programme and National AIDS Committee as the government's first response to the HIV epidemic. In 1997, the National HIV/AIDS Task Force was established to strengthen the national capacity for an expanded response to the HIV epidemic. In 2000, the government installed the multi-sectoral National AIDS Commission (NAC) with responsibilities to coordinate and monitor the prevention and control of HIV in Belize. The newly formed NAC proposed Belize's first strategic plan to streamline the response efforts.

In 2001, GOB presented a status report on the national response to HIV/AIDS at the 26th United Nations General Assembly Special Session (UNGASS). Along with 188 other member states, Belize signed the Declaration of Commitment on HIV/AIDS and as result, the Prime Minister placed the NAC under the responsibility of his Office in 2002. This decision underscored the high level of political commitment to responding to HIV/AIDS. The Commission also included multi-sectoral representation at the highest levels of government, nongovernmental organizations, business, religious leaders, community-based organizations, multilateral and bilateral agencies and people living with HIV/AIDS. In 2008, the National AIDS Commission Act was amended to restructure the NAC Secretariat, moving from an Executive Chair to a Chair and an Executive Director.

The structure of Belize's response to HIV/AIDS is considered unique in Central America and the Caribbean in that the NAC falls under the portfolio responsibility of the Office of the Prime Minister, unlike most other countries where the response is lead by MOH. The intent of this strategy is to foster a multidimensional, human development approach to HIV programming rather than to focus on the epidemic as a health issue alone[31]. Through this approach, Belize has encouraged multi-sectoral collaboration and has successfully mobilized key sectors to become involved.

Additionally, in Belize the NAC and the Country Coordinating Mechanism (CCM) are one and the same. This was intentionally done to reduce duplication of efforts and grant management cost and it was possible as the NAC was already meeting the GFATM representation requirements for CCMs. Belize is one of the few countries in the world that operate on a completely merged NAC-CCM structure[32] and this has made the national processes more open, inclusive, transparent and better resourced.

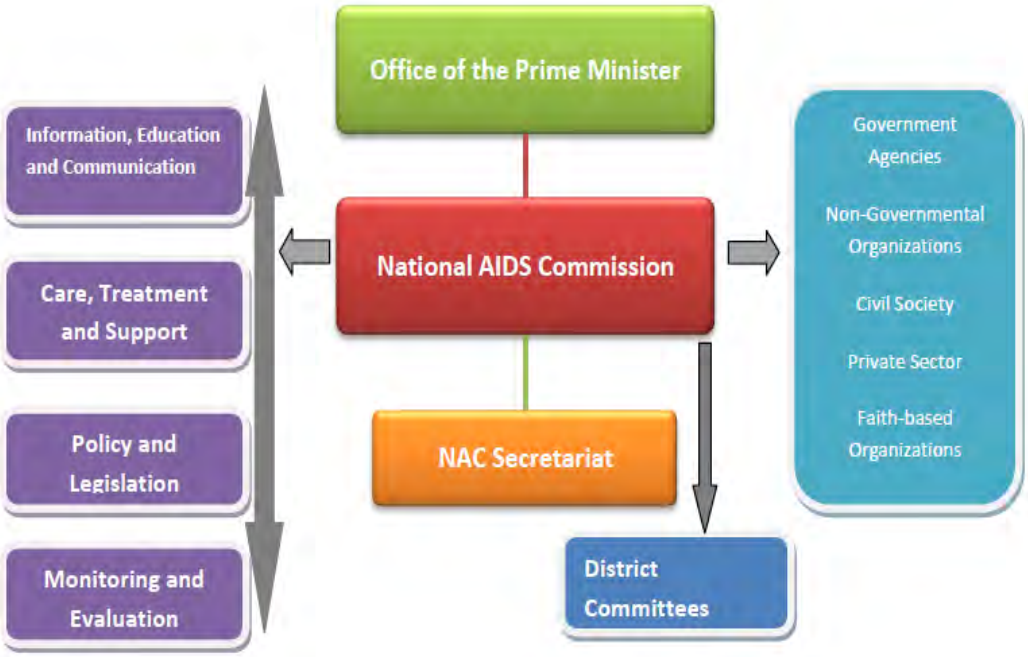
[31] Belize National Strategic Plan 2006-2011
[32] Belize National Coordination Country Case Study, UNDP 2011

## *4.2 Key Actors of the National Multi-Sectoral Response*

**Office of the Prime Minister (OPM):** The primary role of the OPM is to create and maintain supportive environments in which an effective national response can be implemented. Within this ambit, the responsibilities of the OPM may include: promoting the mainstreaming of HIV/AIDS into the management and the response capacity of the public service; promoting the inclusion of HIV response plans into the formulation and implementation of all relevant sector policies and strategies.

**The National AIDS Commission (NAC):** As the high-level coordinating and oversight body for the national HIV response, the NAC carries the voice and force that articulates the national response priorities, advocates for the effectuation of that response and assures accountability of the stakeholders for performance and progress. To perform these functions, the Commission oversees three layers of governance and management including the Commission (and its Sub-Committees for Policy and Legislation; Care, Treatment and Support; Monitoring and Evaluation; and Information, Education and Communication); the District Committees; and the NAC Secretariat.

**Chart 5: Structure of the National Response to the HIV/AIDS Epidemic in Belize**
*Source: National Monitoring and Evaluation Plan 2006-2011*




The Commission is expected to ensure the effective operations and functioning of the Commission itself, including the development and socialization of the overall policy directions of the national response, steering and overseeing the output and operations of the Commission's sub-committees, the District Committees and the Secretariat of the Commission. It is also responsible for receiving and appraising interim progress reports from the monitoring, evaluation and research activities,

linked to the NSP and the NOP; for establishing and applying the planning, coordination and oversight schedules; for ensuring periodic reviews of the national plans and for endorsing shifts or the incorporation of new methodologies for the implementation of the plans.

The Commission's Sub-Committees are tasked by the Commission to hold the necessary technical discussions and/ or reviews and subsequently inform or advice the Commission through offering the findings of reviews and recommendations for decision making; and to ensure full inclusion of all relevant stakeholders, particularly persons with HIV and other vulnerable groups in all activities and initiatives of the particular Sub-Committee.

The District Committees are expected to function as a sub-national level clone of the Commission, coordinating responses at the district level by managing the planning and implementation of local initiatives that are aligned with the national plans, integrating local sector-based plans into the national priorities, and by ensuring that local knowledge finds its way into the planning and review mechanisms of the national response. Responsibilities can include: managing the implementation of the NSP and NOP at the local level; managing the mobilization of local actors, relevant to the proposed response strategies; ensuring local dissemination of all HIV-relevant information and knowledge (policies, technical guidelines, protocols, research, etc.); facilitation of the identification of local-level resources for the sustainable HIV response; acting as the coordinating bodies for the Continuum of Care for persons with HIV; and coordinating the collection and compilation of local level monitoring data.

The Secretariat is tasked with and responsible for: the daily management and coordination of the implementation of the NSP; the management of the multi-stakeholder planning and review processes, including the facilitation of periodic comprehensive reporting to the Commission; the development and coordination of the implementation and monitoring & evaluation of the NOP; the management of the development and implementation of the national HIV/AIDS research agenda; the oversight of financial monitoring and the mobilization of domestic and external partnerships and resources for a sustainable national response; the leadership in the dissemination of relevant knowledge and information as well as the communication and advocacy for an adequate national response to HIV/AIDS.

**The Ministry of Health:** Is the primary stakeholder in the provision of HIV health services by GOB through its National TB, HIV, and other STIs Programme. The programme is essentially a vertical one but contains areas of nascent integration; a successful example is the health care for pregnant women with HIV that is provided through the MCH clinics. As the primary regulator and implementer of HIV response interventions, MOH manages a vital package of prevention and clinical/ biomedical interventions. One of its primary continuing roles is to ensure that the health

care system, including the BHIS, is optimized in order to create maximum efficiency and impact. Specific and paramount responsibilities of MOH include: ensuring the functional integration of all HIV-relevant services, including MTCT, VCT/PITC, TB, STI and SRH; improving testing environments, including laboratories and viral load testing capacities; catering for an increase in the number of persons on ART, earlier initiation of ART, more sophisticated lines of medication, and increased levels of adherence to ART; strengthening and compliance monitoring of staff capacities & performance (especially linked to reducing stigma and discrimination, privacy and confidentiality), guidelines and protocols; and strengthening the health information system and its reporting mechanisms. The comprehensive integration of HIV services into the primary healthcare system remains an on-going effort[33].

MOH continues to scale-up voluntary HIV testing and counselling, while promoting the use of the PITC approach in primary health care facilities. Treatment has expanded beyond the stand-alone VCT centers to seven additional governmental and non-governmental sites. It also continues to improve prevention control by strengthening management and surveillance through the introduction of policies, standards and norms, sustaining the acquisition of ARVs, and planning for the introduction of viral load testing and other innovative approaches to quality HIV care in Belize.

**The Ministry of Education and Youth:** MOEY manages a powerful socializing and cognitive tool that promotes awareness and knowledge and that can enable changes in risky sexual behavior. It is also a tool that, by law, has an extended reach among boys and girls. Furthermore, schools are community-based assets that can influence attitudes and behaviors of neighborhoods. One of MOEY's primary roles is to deliver comprehensive and consistent high quality environments for education and learning in areas that are relevant to HIV awareness, knowledge and behavior; it is the cross-cutting mandate for the holistic development of young persons, 15 – 29, that cultivates linkages between and across sectors to ensure that youth issues, particularly for out-of-school groups, are mainstreamed. Some of the specific responsibilities of MOEY include: strengthening leadership and advocacy for the comprehensive delivery of HFLE at primary and secondary education level; strengthening capacities and pedagogical skills of teachers and counselors to adequately deliver all HIV-related elements of the education curriculum; supporting the undertaking of key research topics in collaboration with tertiary education institutions; developing HIV/AIDS programmes specifically targeting out-of-school and unemployed youth; and coordinating and expanding the implementation of HIV interventions through youth-centered civil society organizations and youth-friendly spaces.

**The Ministry of Human Development and Social Transformation:** MHDST plays a most prominent role at several levels in the regulation and provision of protection and support services –ranging from psycho-social support to financial assistance schemes- to vulnerable persons and families.

[33] Evaluation of the Health Sector Response to HIV, 2010

MHDST is in the process of developing the Single Information System for Beneficiaries (SISB), a tool that will allow the identification and targeting of specific groups for inclusion in social safety and protection programmes. Some of MHDST's specific responsibilities include: to lead the advocacy for safety and protection measures for girls and women at risk of or experiencing violent and exploitative living circumstances; to incorporate into the SISB and its portfolio of social protection programmes avenues to identify and reach persons infected, affected and susceptible to HIV/AIDS with a country-wide focus on girls and women, OVC and persons with HIV; to be the lead regulator and provider of professional services in the area of psycho-social counseling, social work and conflict resolution; and to regulate the transparency and accountability of NGOs working in the HIV response via the registration protocols for NGOs.

MHDST's Women's Department continues to implement the Gender Awareness Safe School Programme at the district level which includes interactive sessions on topics such as Domestic Violence, Gender Sensitization, Sexual Harassment, Self-Esteem and HIV. The programme targets primary and secondary school students with the objective of setting a foundation for gender equality amongst boys and girls inside and outside of the school settings.

**The Ministry of Labor, Local Government and Rural Development:** MOLLGRD manages a wide range of portfolio responsibilities. It manages the regulation, enforcement and arbitration of issues related to the world of work as well as linking central levels to the various local levels of municipalities and villages. Specific responsibilities in relation to the HIV national response include: the continuation of the ministry's lead role in advocating for and enforcing the comprehensive implementation and application of the National HIV/AIDS Work Place Policy; the identification and mobilization of neighborhood and community structures in support of the implementation of HIV/AIDS programmes; and the strengthening of the capacities and role of the District Committees. MOLLGRD has been instrumental in the development and implementation of the 2006 National HIV Workplace Policy. The Ministry's HIV Workplace Education Programme was initially implemented in five sectors and within 18 companies. It has grown to include 40 companies impacting over 6,000 employees.

**The Ministry of Tourism / Belize Tourism Board:** The Ministry, through the mandate provided to the Belize Tourism Board (BTB), plays the most prominent role in the regulation of the operations in the tourism industry. It has developed strong levels of collaboration with the various private sector tourism-related associations. Some of the specific responsibilities include: to ensure that legal and policy provisions for the regulation of the tourism sector include provisions that discourage commercially-based sex tourism; to advocate for and ensure the protection of young women, MSM and FSW in relation to their possible involvement in the tourism industry; to ensure that all formal and informal professional workers in the industry, and their respective associations, are fully informed and educated on all aspects of HIV/AIDS.

**The Ministry of Police and National Security:** The Ministry has regulatory and oversight responsibilities, which include the supervision of the prison system. The Ministry has the responsibility to ensure that male and female inmates have full access to condoms and SRH education and services, while in the custody of the state. The Ministry also holds responsibility to protect inmates from all forms of violence including gender based and sexual violence.

**The Ministry of Finance:** The Ministry ensures that appropriate levels of resources for a sustainable response are allocated to and earmarked in the national budgets or mobilized from external sources, where possible and appropriate. Specific responsibilities may include: support to the articulation of methodologies for results-based planning and reviews; supporting cost-benefits studies and analyses of major programmes; adopting flexible funding ceilings, allowing mobilized external funds to function as additional as opposed to alternative resources; preparing the roadmap to long term and sustainable investments, required to contain the prevalence of the HIV chronic disease.

**The Private Sector:** The involvement of the Private Sector in the national response has not been realised to its fullest potential. Some private sector entities have moved forward and have contributed to the implementation of the National HIV/AIDS Workplace Policy. It will be beneficial to the effectiveness and sustainability of the national response to strengthen the sector's involvement. Specific elements that can be contributed by this sector are: sharing and applying private sector marketing and branding tools and techniques for the implementation of the national response; further mainstreaming of HIV/AIDS into the internal and external domains of private sector enterprises as well as mentoring other private companies in terms of corporate responses to HIV/AIDS; using logistics networks and advertising channels to support the national response.

**Civil Society:** Civil Society, a term for the collective of community, faith-based and non-geovernmental entities, is the key social partner in the national response. Civil Society reaches out to corners, spaces and domains, where the public and private sectors don't reach. Responsibilities of Civil Society can include: identifying and assisting community structures to mobilize human, financial and material resources; strengthening the leadership role of civil society in advocacy and lobby activities; improving the coordination and representation mechanisms among civil society organizations and between civil society and other stakeholders; improving result-oriented implementation and monitoring of the elements in the national response; promoting and supporting the empowerment of persons with HIV and persons vulnerable to HIV, as well as their networks and communication channels.

There is a high level of civil society participation in the national HIV response, but coordination for efficiency and effectiveness is often weak. This involvement has been successfully institutionalized within the structures of the NAC (Commission as well as its Sub-Committees) with decentralized off-shoots in the form of District Committees. As part of the preparations for the formulation of the NSP

2012 – 2016, an in-depth exercise was undertaken in the comprehensive mapping of actors in the response and delivery of HIV/AIDS-related services and goods.[34] Data demonstrates that most participating organizations implemented or supported prevention activities and most of the identified organizations work predominantly in Belize City. Civil society groups indicate that limited availability and access to resources is one of the largest barriers to full participation in the national HIV response; the national resources provided to civil society are minimal while many entities do not meet the organizational requirements to enter successfully the various avenues of donor funding.

**Key Affected Populations:** Due to the high level of stigma, discrimination and marginalization of persons with HIV and persons belonging to sexual minorities, the cultural unacceptability of commercial sex services, and weak organizational structures for and of young Belizeans, persons belonging to key population groups vulnerable to or affected by HIV, have been unable to create entities that can represent their interests in the national response. There is a lack of significant involvement of persons with HIV or vulnerable to HIV in planning, implementation and monitoring and evaluation of programmes at the national and local level. This has been exacerbated by the limited financial and technical support to District Committees, support groups for persons with HIV and platforms for MSM, transgender populations and sex workers. In many cases, interests and rights of groups most vulnerable to HIV have been represented by proxy by non-governmental organizations who provide prevention, care or support services to the affected populations, aiming to assist and empower those groups. Over the past years, key affected groups have been stepping up to the plate. The United Belize Advocacy Movement (UNIBAM), an organization with a membership base in persons with HIV and sexual minorities, is building the capacity of its constituents to become human rights defenders. It focuses on data collection, legal advice and advocacy, and participation in legal reform mechanisms. With support and technical advice from the Central American network of persons with HIV, REDCA+, a new Belizean organization of persons with HIV, the Collaborative Network of Persons with HIV (C-Network) was recently formed.

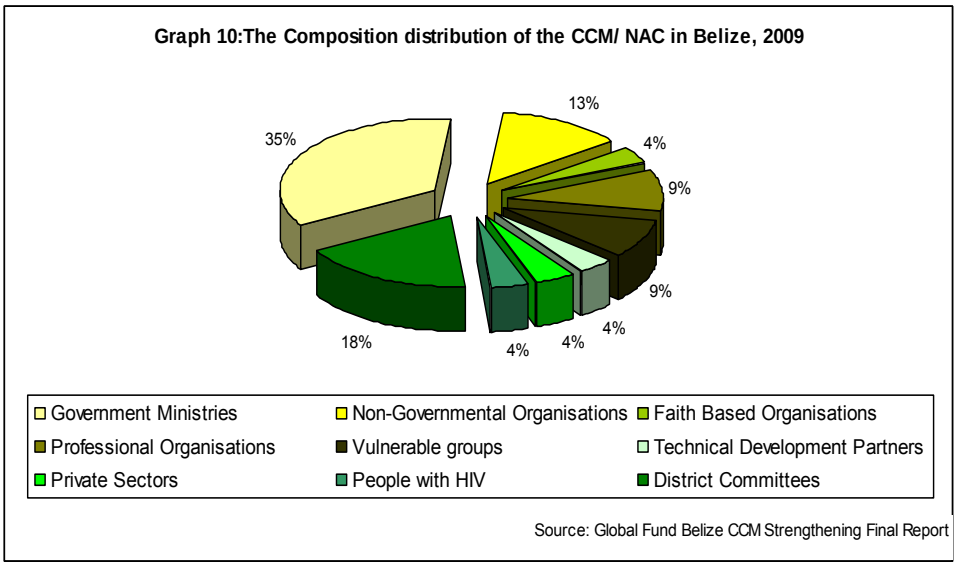
**The Development Partners:** It is expected that the partnership with development actors will continue to promote and enhance the effective implementation of the national response. Development partners will bring to bear global experience while defining and providing specific contributions to the overall planning and implementation of the response. Specific responsibilities may include: upholding the PARIS Principles of Aid Effectiveness; facilitating information and knowledge exchange; channeling technical assistance through a single entry point to avoid duplication; focusing on capacity development opportunities for empowering duty bearers and rights-holders; remaining with an adaptable position to respond to emerging priorities; supporting the innovation of methodologies for planning, coordination, oversight and communication.

[34] http://www.pasca.org/sites/default/files/partii_mapping_the_response_belize_march_2011.pdf

## *4.3 Coordination and Response Mechanisms*

**National Multi-sectoral Coordination[35]:** The Belize Country Coordinating Mechanism (CCM) is guided primarily by the guidelines set out by the GFATM and in conformity with the National AIDS Commission Act of 2004. Coupled with the merged NAC/CCM, Belize has also made considerable strides in implementing the "Three Ones" principles with one national strategic plan, one national AIDS coordinating authority and one national monitoring and evaluation plan. The NAC is mandated to coordinate the overall multi-sectoral response and to implement the NSP.

In 2009, the CCM membership conducted a self-assessment based on the elements of Good Governance developed by GFATM. The elements included composition, oversight, communication, governance, participation, and representation. According to the Belize National AIDS Commission Act, 15 of the 23 members, appointed as NAC commissioners by the Act, represent Civil Society. Excluding the representative of the United Nations Joint Team on AIDS (voice without voting privileges), 14 members (60%) belong to the non-governmental sector. The NAC/CCM has recognized the need to consider its expansion to include other key affected populations for HIV and TB as well as organisations involved with gender and HIV, including those engaging men and boys. The difficulty of choosing these representatives in a transparent and participatory way remains, as there exits limited mechanisms for communication among and within the groups.




The CCM members also indicated that the current CCM structure and organizational culture is only partially supportive of the flow of information and communication[36]. This includes both the communication channels between the CCM/NAC, the GFATM Principal Recipient entity and the GFATM Local Fund Agent; and between the Civil Society members in the CCM and their constituencies.

In an effort to improve communication and adapt a more decentralized approach the District Committees act as the coordinating bodies at the community level. These committees advocate for

[35] GFATM Belize CCM Strengthening Final Report, Alberto Gonima, 2009
[36] Idem

the provision of services at the community level and this structure provides the forum for networking and sharing of experiences for greater expansion of the response[37]. Challenges include the lack of a structured feedback mechanism to ensure an inclusive and transparent decentralized response.

**Health Sector Response[38]:** The Belize Health Sector Reform Program has facilitated several advances in the HIV/AIDS prevention, care, treatment and support program. A rapid assessment of the SRH and HIV linkages in Belize showed that the policy and legislative framework is supportive for the integration of SRH and HIV services into primary health care system[39]; other advances include the integration of HIV, TB and STI management as well as the integrated approach of antennal care. However some weaknesses that affect HIV outcomes remain, and action and advocacy are needed to push for effective policy development and implementation of the integration and decentralization of HIV services into the primary care system.

The main hindrances to an effective integration process and the continued vertical programming of HIV services within a decentralized health system are the limited human and financial resources. In addition, decentralization is often viewed in terms of administrative and management duties, but not of responsibilities or resources which continue to be managed at central level[40].

In 2008, MOH updated the national HIV testing and counselling guidelines that speak to improved integration of services and efficient use of resources. Currently MOH is finalizing revised treatment guidelines that will seek to improve service delivery for people with HIV. Guidelines and standards related to patients' rights, patient-focused approaches, procurement and supplies management, forecasting and laboratory operations remain in need of upgrading.

The current ratio of health care providers per 10,000 population is 18.9 and falls below the WHO-recommended optimal ratio of 25. A net annual growth of 59 health care providers is required to keep pace with Belize's population growth of 4.3% per annum. Based on the current situation, a net annual increase of 26 physicians, nurses and midwives is needed to accommodate population increases. When aiming at the WHO-recommended ratio, an additional 32 medical staff per annum is needed by the year 2015. A failure to achieve this target will likely result in the continued burnout of medical professionals, high staff-turnover rates and the delivery of substandard health services to the general population as well as people with STIs, TB and people living with HIV.

[37] National Coordination of AIDS Responses: The Case of Belize, UNDP 2011
[38] GFATM Round 9 Proposal: Accelerating the Pace: Reaching Marginalized and Vulnerable Populations with Critical Services, Belize 2009
[39] Rapid Assessment of Sexual and Reproductive Health and HIV Linkages, Belize 2010
[40] GFATM Round 10 Proposal, Keeping the Course: Empowering Most-at-Risk Populations to Reduce their Vulnerability to HIV/AIDS in Belize, 2010

Belize is classified as lower-middle-income developing country in the Latin America and Caribbean Region[41]. High poverty levels paired with substantial inequalities, a struggling economy that shoulders a level of public debt of almost 90% of GDP, nascent institutional capacities and stagnant levels of development assistance have created financing obstacles to effectively address health system weaknesses. The majority of the national HIV budget is allocated to MOH, particularly to the National AIDS Program, and is spent on personnel costs, ARVs and OIs. The significant financial GOB contributions to the health system need future evaluation to ensure that efficiencies are being exploited.

Belize developed and implemented the BHIS, which includes modules for HIV and Supplies Management. The BHIS harbours a great capacity for enhancing the management of patient health information; the implementation of this health information system in Belize is an extraordinary accomplishment and the efforts of MOH and relevant stakeholders are to be commended. However, simultaneous investments in building human resource capacity need to continuously occur.

Weaknesses and inefficiencies in procurement and supply chain management compromise the delivery of quality services. They also impact the quality of treatment, especially when numerous medications are used to formulate regimens, by increasing the incidence of stock outs. Response efforts include the establishment of a "virtual warehouse" in the BHIS, and a CMS warehouse, built to international standards. A plan for strengthening procurement and supplies management (PSM) has been developed, and awaits implementation.

**Community-Based Response[42]:** Community-led structures and mechanisms for community-based interaction and coordination deliver their outputs in response to the challenges and needs that affect their communities; they are therefore important tools in the national HIV response. However, despite the presence of numerous community-based organisations and actors, levels of effectiveness and sustainability vary widely.

One of the critical social enablers for an effective HIV response is community engagement and advocacy that can positively influence the policy, legal and governance environments, as well as the social determinants of health. One of the main hindrances to an effective community-based response is the limited coordination and collaboration among community-based groups in tackling the localized needs. A number of additional factors play a limiting role: Lacking guidance and capacities, many CBOs involved in the HIV response struggle to articulate their strategic role and function within the national response strategy. They are often disconnected from the operational centre and the flows of information and communication; most CBOs evolve from an ad-hoc

[41] http://data.worldbank.org/country/belize
[42] GFATM Round 10 Proposal, Keeping the Course: Empowering Most-at-Risk Populations to Reduce their Vulnerability to HIV/AIDS in Belize, 2010

conglomeration of volunteer groups and often have weak organizational governance, leadership and accountability systems in place.

Stakeholders agree on the need to strengthen the community based response to HIV and are exploring funding opportunities for a comprehensive tailored capacity building programme. Recently, two CBOs formalized their legal status and participated in a leadership capacities development programme: the Collaborative Network of people living with HIV (CNET+) and Tikkun Olam, which advocates for strategic approaches to sexual and reproductive health among female sex workers.

The inability of CBOs to attract human resources with appropriate personal, technical & organizational capacities, as well as to attract sufficient levels of financial and material resources (infrastructure, information and essential medical & other commodities & technologies) is a major constraint. A situational assessment made for the GFATM Round 10 proposal, identified a wide-spread need for technical capacity building for comprehensive project management structures and functions. The lack of these capacities contributes to high staff turn-over and constructs a vicious cycle that obstructs growth and maturation.

CBOs are no exception to the overall weak national culture of monitoring and evaluation. There is very limited capacity for data analysis, identifying and documenting key information and lessons learned required for improved and strategic approaches in community mobilization.

**Chart 6: HIV Continuum of Care**

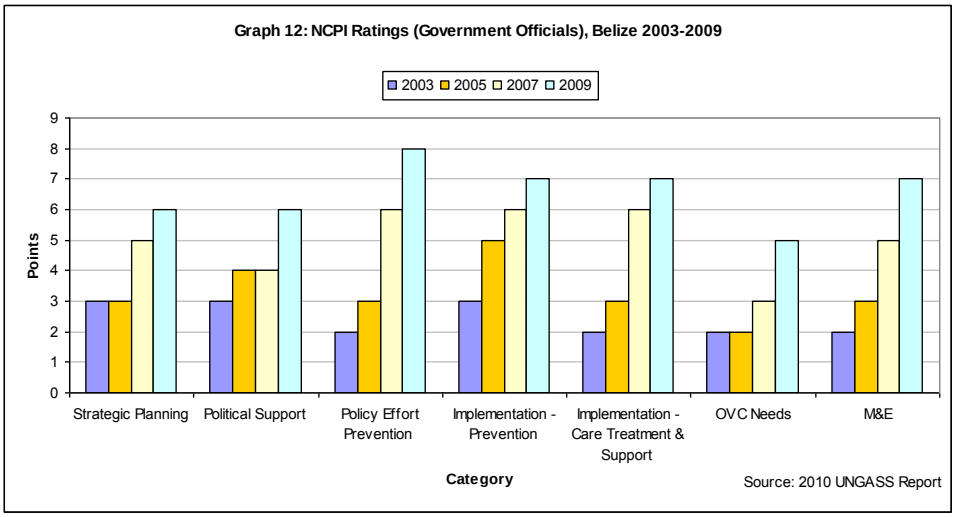
*Source: National AIDS Commission 2011*

## *4.4 The Legislative and Policy Environment*

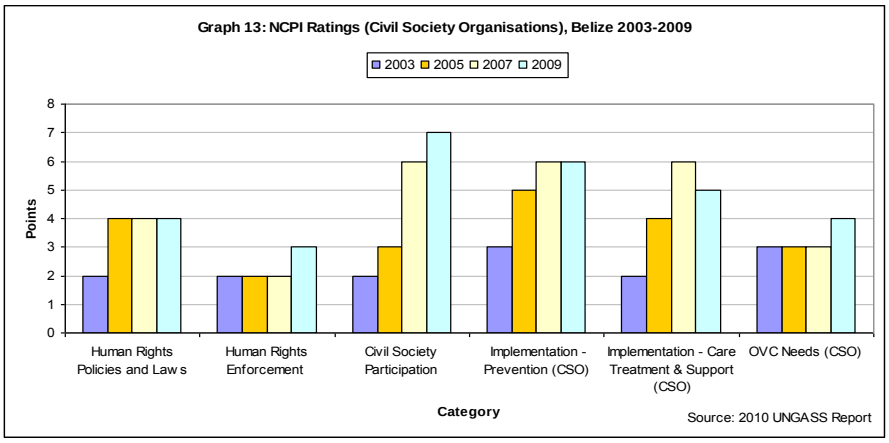
The **2009 National Composite Policy Index** (NCPI) provides assessment values for the policy and legislative environment in Belize. The assessment showed that despite the existence of laws and regulations that protect the rights and freedoms of all persons in Belize, there are also laws and

regulations that pose serious obstacles to key populations in Belize, and that fuel stigma and discrimination, particularly for persons with HIV, women and girls, young people, SW, MSM and transgender persons. Additionally, the assessment indicated an absence of programmes designed to empower persons with HIV to claim their rights and reduce stigma and discrimination.

HIV in Belize is classified as an infectious disease by the Statutory Instrument 32 of 1987; additionally section 2 of the Quarantine Act which includes venereal diseases as infectious diseases including HIV, and section 46.01 and section 73.01 of the Criminal Code create offences of wilful and reckless transmission of HIV. Historically, Belize has not acted on these legislations with regards to HIV; however their mere presence instils fear of stigma and discrimination in persons with HIV and those perceived to be at higher risk of becoming infected. The NAC is spearheading an initiative to alter laws and regulations, such as the criminalization of HIV transmission and those that criminalize same-sex sexual activities between consenting adults.




In a climate of financial and economic challenges over the past 5 years it remains difficult for the GOB to increase public attention to the social and economic impact of HIV/AIDS. Despite advances such as the development and adoption of the National Policy on HIV/AIDS and the subsequent legislative review and advocacy initiatives to revise and update legislation on a human rights platform, there has been little change in the policy environment.




Regarding policy efforts, the NCPI indicated that despite HIV policy development, the enforcement of policy and regulations remains low, mainly attributed to limited rights holders' knowledge about existing policies. Additionally, the redress mechanisms, in place for persons with

HIV and vulnerable populations when faced with discrimination, are assessed to be limited and not well articulated. The majority of respondents indicated that the NSP addressed most of the key national issues, although some aspects (e.g. gender and human rights) remained under the radar. Most respondents indicated that the NSP did not include achievable goals and objectives for the timeframe allocated. There was also limited consensus among stakeholders on the implementation of the national strategy. Although most agencies developed their own strategic plan, less than half of the respondents indicated that their agency used the national strategy when developing those agency plans. In relation to financial resources, most respondents indicated that there was no mechanism for resource mobilization and the available funding was not sufficient for the organizations to carry out their roles and responsibilities.

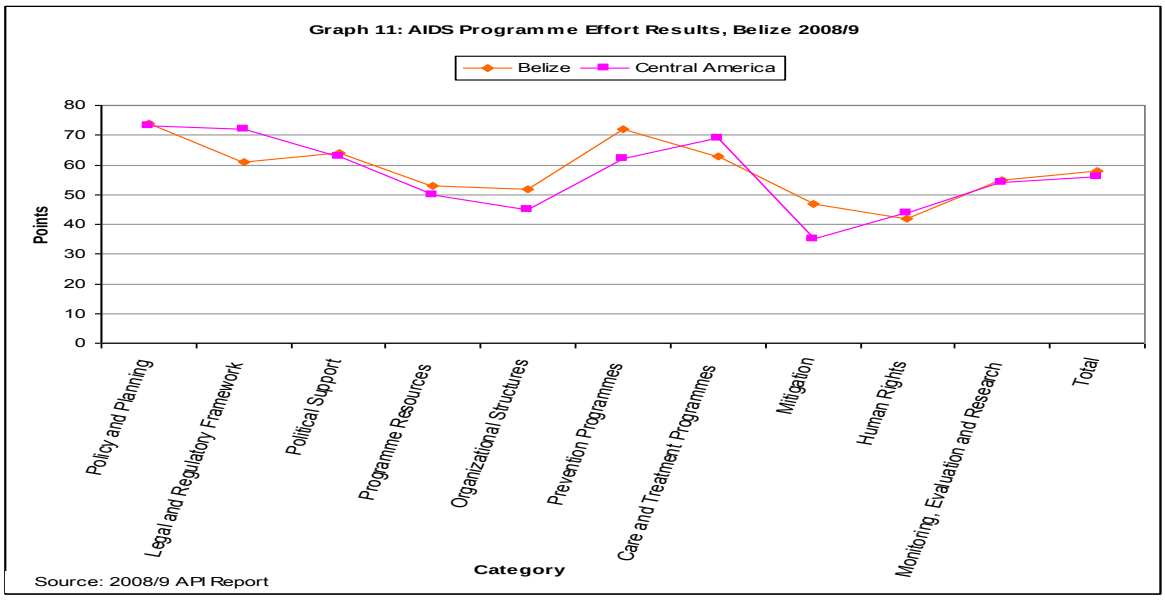
Stakeholders indicated that there was limited improvement in the effectiveness of the leadership role of the NAC and the district committees, that there was moderate improvement in the effectiveness of the coordination role of the NAC, limited improvement in the evidenced-based planning of the response, and limited effectiveness in the creation of an enabling environment for the reduction of stigma and discrimination of people with HIV. Respondents noted significant improvements in programmes for the reduction of HIV transmission through blood products and mother to child transmission, moderate improvements in programmes targeting reduction in HIV transmission among young people, limited improvements in programmes targeting reduction in HIV transmission among vulnerable groups, and moderate improvements in other prevention services. They also indicated limited improvements in the effectiveness of integrated care, treatment and support services for persons with HIV and limited improvement in policies and programmes addressing reduction of the socio-economic impact for persons with HIV.

The NCPI also reported increased access to information, education and communication as a result of partnerships in targeted interventions. It also highlighted the successes resulting from the scale-up of the PMTCT and VCT programmes, including increased involvement of civil society in the provision of voluntary counseling and testing across the country. Challenges identified include the lack of a formal operational and resource mobilization plan for the NSP, resulting in limited coordination between “resource-driven” HIV activities and the national strategies. Additionally, an increased involvement of persons with HIV and vulnerable populations was mainly inhibited by capacity gaps. Improvements were noted in the area of government support and advocacy, resulting in the earmarking of HIV budgets in key front-line government ministries and departments. However, national funds provided to civil society for the implementation of HIV programming remain minimal to non-existent.

Overall, limited involvement of persons with HIV and vulnerable groups, limited to moderate involvement of government agencies, and moderate involvement of non-government agencies was reported. Respondents felt that the NSP was not being implemented equitably among the different

vulnerable groups and felt that persons with HIV constituted the most underserved population group. The majority felt that the NAC was monitoring the NSP; however the majority did not feel obligated to report progress to the NAC. And the majority was receiving no feedback on the implementation of the NSP.

The **2009 AIDS Programme Efforts Index** (API)[43] score is 58 points (out of 100), which is comparable to the rest of Central America (57 points). The programme effort areas Policy and Planning, and HIV Prevention Efforts received the highest scores, while Human Rights scored the lowest followed by Mitigation. High scores in the area of political environment were attributed to the existence of a National HIV Policy and a National Strategic Plan, both developed in a participatory manner involving government and civil society.




Lower scores in the legal and regulatory framework were linked to the absence of programmes, policies and laws that protect persons with HIV and members of vulnerable groups from stigma and discrimination, as well as, significant gaps between the existence of these frameworks and their implementation.

In the area of care and treatment programmes, Belize's low score is attributed to the limited availability of preventive therapy for persons with HIV, limited intensive case finding and treatment for TB in persons with HIV, limited psychosocial support and palliative care for persons with HIV and their families, as well as limited provision of antifungal medication for OIs and treatment for HIV-

[43] The API is a methodology used for measuring the political environment as it relates to the implementation of a national multi-sectoral response to HIV. The index measures the programmatic effort areas, including Policy and Planning, Legal and Regulatory Framework, Political Support, Programme Resources, Organizational Structures, Prevention Programmes, Care and Treatment Programmes, Mitigation, Human Rights, and Monitoring, Evaluation and Research. The various scores within the full spectrum from Policy& Planning to Evaluation, Monitoring & Research, reflect the average scores given by respondents to the API exercise. Scores therefore reflect the average opinion on the level and impact of HIV efforts in Belize.

related cancers. Mitigation received higher scores than the rest of Central America primarily because Belize recognized and appreciated the need for community action in responding to HIV and funding was allocated to such activities.

The Human Rights score was slightly lower than the rest of Central America. High scores were assigned to areas related to the ratification of international Human Rights instruments; low scores were assigned to the aspects of limited promotion of an enabling environment to enforce laws and regulations related to human rights and HIV as well as to reduce stigma and discrimination. In addition, legal support services were assessed as insufficient as well as the limited impacts of oversight bodies.

## *4.5 Strategic Information Management*

The National Strategic Plan 2006-2011 has an accompanying Monitoring and Evaluation Plan aimed at guiding the oversight and performance monitoring of the national response; however the monitoring of the NSP 2006-2011 did not materialize. A modified M&E tool for warehousing, management and dissemination of aggregated HIV information (HIV-Info) exists in rudimentary form but is not in functional use. The NAC has a monitoring and evaluation sub-committee which is mandated to operationalize and implement the M&E plan. The strengthening of the national monitoring and evaluation system is a major thrust of the evolving HIV response; several introductory-level training activities have been delivered and a recent stakeholder consultation was held to assess and define a number of response interventions for the strengthening of the national HIV monitoring and evaluation system. The results of the assessment were molded into a Plan of Action for the Strengthening of Monitoring and Evaluation Systems.

Routine programme monitoring and evaluation is currently not institutionalized in the national response. Data collection occurs mostly for specific purposes linked to donor reporting and/or to periodic reporting in light of international commitments. Although each actor in the response might collect data based on the needs of a specific programme, there is no data flow requirement to or from the NAC. Additionally, there is no functional aggregate data management system at the national level. Efforts are being made to build the capacities of the actors in the national response to support the institutionalization of a sound strategic M&E framework.

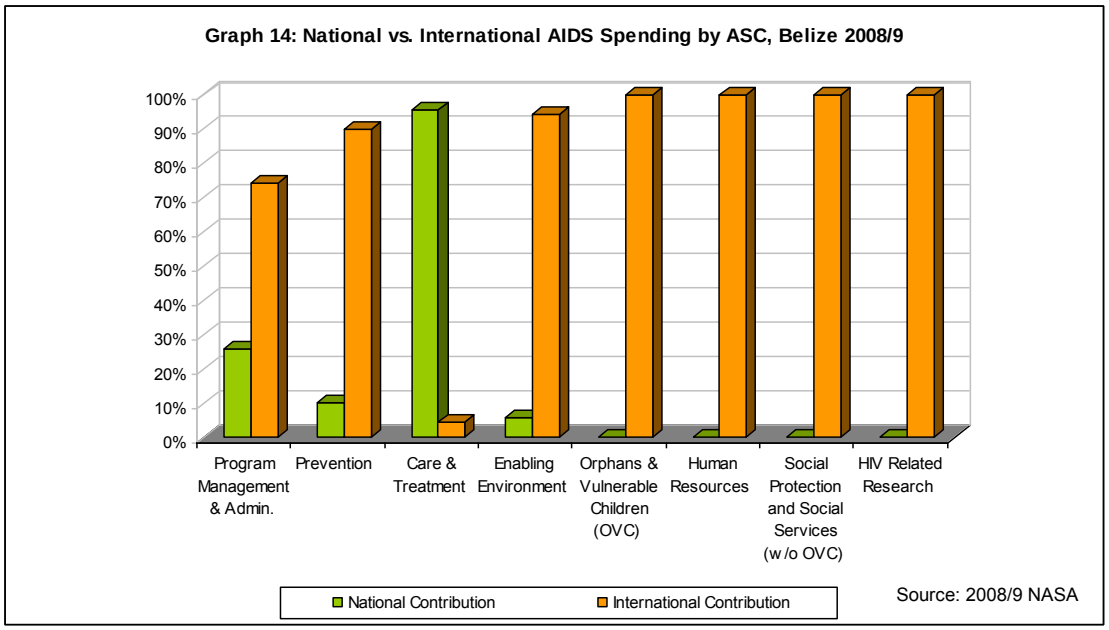
Belize conducted the first National AIDS Spending Assessment (NASA) in 2010 during the preparations for UNGASS reporting. The NASA provides a framework and a tool for the comprehensive analysis of actual expenditures for HIV/AIDS (both health and non-health related activities). In 2008, preceding the development of the GFATM Round 9 proposal development process, a Resource Needs Model (RNM) for the 2006-2011 NSP was developed to facilitate the determination of a financial Gap analysis for the national response. There is limited strategic analysis

of these two documents and the impact of resource availability levels on the implementation of the NSP.

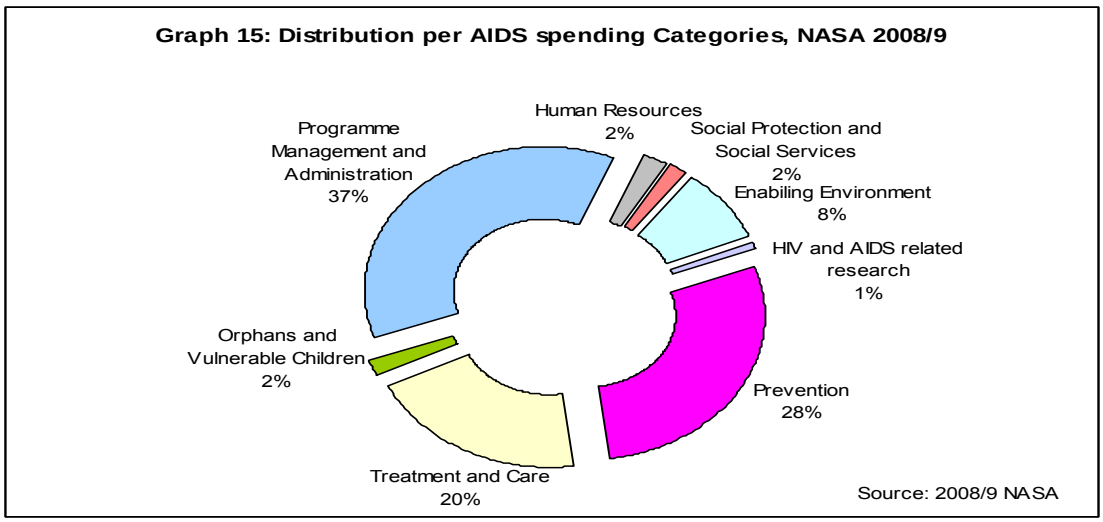
Surveillance data needed for decision making is not routinely collected in Belize. The absence of a research agenda, financial constraints and weak mechanisms for conducting second generation surveillance hinders progress in this area. Additionally, there is no strategic guidance to the implementation of research initiatives which are based primarily on donor demands.

## *4.6 Resource Mobilization, Allocation and Spending*

The NASA exercise was conducted in Belize for the period April 2008 to March 2009 in line with government's fiscal period 2008/2009 and provides useful information on strategic investment planning, resource mobilization and budget allocations; however the absence of an analysis of the these data along with the results from the resource needs modelling, which lead to assessments of the financial gaps and the effectiveness and efficiencies of response programmes, greatly confines the usefulness of the NASA in strategic planning.




The NASA reported a total spending of BZ$4,922,545, which represented 6.8% of the National Health Budget of BZ$ 72.8 Million for the same period. GOB contributed 31.8% or BZ$ 1,283,494 to the total

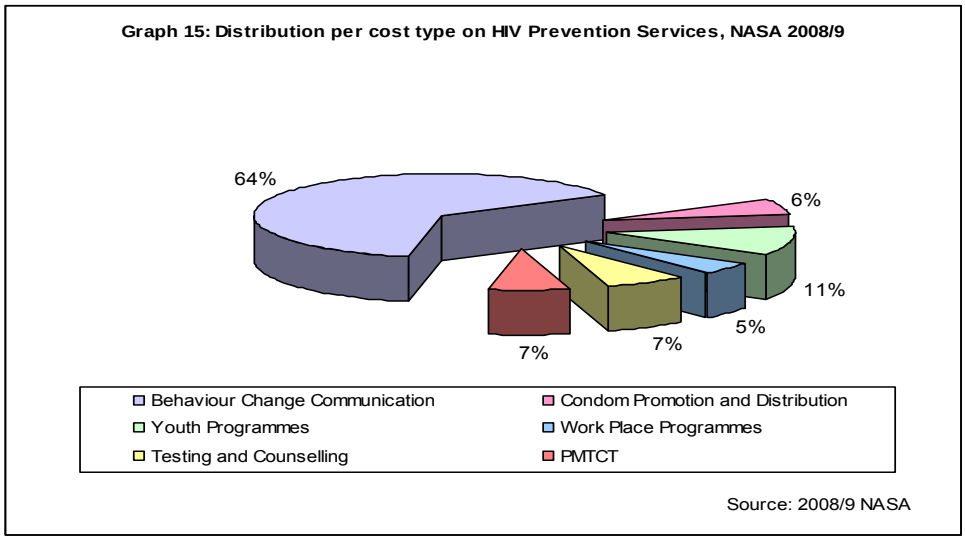



cash spending, while international donor agencies contributed 68.2% of the national spend or BZ$ 2,757,312. Of the total combined national spending, 17.9% or BZ$ 881,739 was non-monetary donations. The majority of the government expenditure was for care and treatment for people with HIV and Programme Management, limited contributions to enabling environment and prevention.

The Programme Management and Administration represented the highest expenditure area (36.7%) followed by Prevention (28.4%) and Care and Treatment (19.9%). Programme management and administration represented the highest AIDS Spending Category of which 78% was assigned to the sub-category planning, coordination and programme management. This sub-category reflects expenditure incurred at the administrative level outside the point of health care delivery including dissemination of strategic information, planning and evaluation of prevention, treatment, care and support efforts; coordination of the response and the implementation of the three ones principles. The annual subvention of the NAC Secretariat amounted to 80% of the total program management expenditures[44].

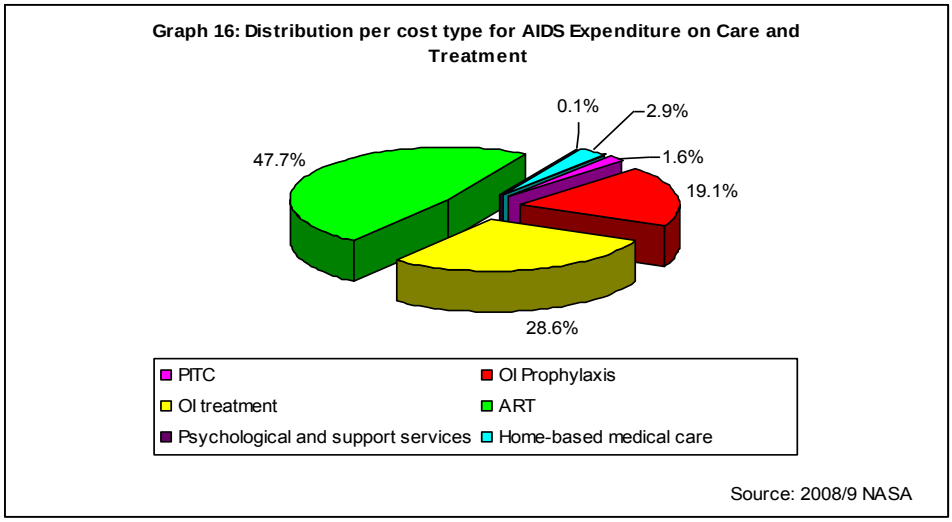
The global economic slow-down has affected funding levels of NGOs for Programme Management and Support costs. Despite the continuous supply of project funds, programme management costs are often not included in the grant proposal or are under-estimated. Issues of productivity, efficiencies and effectiveness of programme management structures need to be further analysed and strengthened.

[44] UNGASS Country Progress Report, NAC Belize, 2010




With 28 % of the total expenditures, prevention programmes represented the second highest AIDS expenditure during the fiscal year 2008/9, 64% of that amount was spent on BCC programmes, and the remaining 36% was spent on PMTCT, VCT, youth programmes, work place programmes, and social marketing/ condom distribution as shown in Graph 15. There is limited analysis of the effectiveness of the programmes being made and no indication of the value for money or return on investment into BCC initiatives. With decreasing condom use among FSW and MSM and low consistent condom use in young people, more research and analysis is needed to inform the choice and effectiveness of the current prevention approaches in Belize.

Care and Treatment constituted the third highest HIV expenditure category at 20 % of the total HIV expenditures. In the fiscal year 2008/9, 48% of the total expenditures in Care and Treatment were recorded as ART for adults, while another 48% went to the prevention and treatment of OIs.




Less than one percent of the resources went to psychological and support services. When analyzing the target groups for care, treatment and support services, persons with HIV accounted for the majority of the total cash spending, followed by persons vulnerable to HIV infections.[45]

[45] Analysis of the Situation and Response to HIV in Belize, 2011

One of the major constraints in scaling up the response to HIV is the availability of resources. The global economic crisis has led to a paradigm shift as funds are now allocated on the basis of the epidemic profile of the country. Strategic investment planning must trickle down to the country-level response to make national responses attractive for donor financing. The revision of strategic plans must be followed by a comprehensive modelling of the resource needs and the undertaking of a gap analysis. Additionally, the simultaneous development of a quality and relevant operational plan is a necessary condition to strategically position the new strategy for attracting donor funding. There is also a need to use the NASA, The Resource Needs Model and the NOP in the development of a strong evidence-informed resource mobilization strategy. NASA 2008/9 data showed that programme management costs were the highest expenditure, pointing at a need for greater efficiencies in the comprehensive management of the national response and raising the question of effectiveness of the response as investments are not delivering the required results at beneficiaries' level. The financing, required to end HIV infection in Belize, is significant and current resource allocations are not enough. In a constrained financial environment the country needs to develop a strategic investment plan built on good value for money and long term, high impact strategies.

## *4.7 Problem Tree Analysis and Remaining Gaps and Needs*

**Legislation and Policy:** Some legal frameworks and policies hinder the enhancement of enabling conditions and equal opportunities to access and utilization of services provided by the state. There is a need for specific legislation that provides the legal basis for the National HIV Policy and covers the area of equal rights for sexual minorities, orphans and vulnerable children (OVC) and SRH/ STI testing services for persons under 18. Of utmost importance is the removal of punitive laws and policies, including those criminalizing the transmission of HIV and same-sex sexual activities of consenting adults. New legislation and amendments to existing legislation need to protect women and children, persons with HIV and sexual minorities, while providing universal access to prevention, care, treatment and support services, particularly for young people.

**Stigma and Discrimination:** The response needs to intensify mitigation efforts toward the negative influence of stigma and discrimination on levels of professional service delivery, and to change attitudes towards and perceptions of vulnerable groups among the general public and among marginalized groups and others susceptible to HIV. Empowerment of persons with HIV is an important element in creating agents of change within their own community; it enables the growth of new partnerships that address stigma & discrimination, poor socio-economic living conditions and avoidable absence of livelihood opportunities.

**Human and Legal Rights:** Human Rights and Stigma Reduction remains a major thrust and core pillar of the advocacy work of the NAC. In general terms, there has been limited programming for stigma and discrimination reduction in Belize. Civil society is the primary stakeholder in this area and most

activities are implemented on a small scale; in particular, most activities address stigma and discrimination against MSM. The GFATM Round 9 grant has planned a mass media campaign geared towards reduction of stigma and discrimination. Consultations with MSM and FSW in 2008 indicated that stigma and discrimination constitutes the primary barrier to accessing services. A 2007 survey of health professionals indicated issues of stigma and discrimination in the health care workforce, particularly as it related to marginalized groups. The MOH conducted a series of education and sensitization training sessions with health care providers aimed at S & D reduction.

**Multi-Sectoral Coordination:** Despite the presence of a singular strategic plan, many actors in the national response plan and implement their programmes in an isolated way, focusing on priorities of their own or of their donors. Often these programmes are further inhibited by the capacities of the partner agency to implement such programmes. As a result the activities being implemented are not effective or gap filling. The NAC is mandated to build greater synergies and promote a more integrated approach to implementing the one national strategy. This requires a well facilitated coordinated response at national and district level. One important actor in this multi-sector decentralized approach is the District Committee, which needs significant capacity building and streamlining. Joint planning and programme implementation at the community level would also consider the advantages of the communities being targeted as well as the comparative advantages of the actors serving the particular community. Another identified weakness of the response is the flow of information to and from the NAC to the implementing partners.

**Sustainability of Response:** Lack of continuity of programmes may affect its effectiveness. Programmes that depend heavily on short term external funding may result in the implementation of one-off programmes that may end when the funding is no longer available or the implementer changes its priorities. Ensuring the sustainability of the response consideration must be given to the long-term impact of the intervention. Effort must be made to strengthen community systems to ensure that programmes are designed to address the long term needs of the community rather than short term bandages of the symptoms. Strengthening the District Committees would also lead to the strengthening of mechanisms to jointly plan, raise resources, implement programmes and monitor and evaluate its effectiveness. In tandem with the sustainability effort is the need to have an integrated approach for HIV service delivery. Integration of HIV prevention, treatment, care and support services at all level of the national response would lead to the incorporation into existing structures that are sustainable in the long term. This in turn would improve the continuity of services and provide better efficiencies and value for money.

**Institutional and Human Capacity:** The multi-sectoral approaches and collaboration remain the cornerstones of the response success but due to the evolution of the disease and the financing parameters, new innovative approaches are required to effectuate a transition of the financing

paradigm towards a more sustainable model, brokering the comprehensive mainstreaming and adoption of HIV/AIDS responses into sectoral plans, programmes and budgets. The NAC is to manage the changing environments while ensuring stability in the area of Donor Coordination (harmonized inputs, aligned reporting, clear accountabilities), Risk Management (the effectiveness of the organization, the data environment) and Change Management (innovation & flexibility of the response, Shared Responsibilities). There is a need for more accountability-oriented coordination as plans of implementing agencies and donors are not always linked to the NSP and/or the national HIV Response Calendar, increasing the risk of duplication or disjointedness of interventions as well as risks of poor reporting. This new level of coordination will have to lead to institutional arrangements that can prevent re-emergence of "conquered" aspects of the epidemic and that will bring collaborating institutions to the same level of innovation and desire for change. Corrective action is required to remedy the inequitable distribution of qualified health personnel, medical equipment and supplies in urban versus rural areas. Additionally, limited organization, leadership and active membership among district committees warrant new investments to build the managerial and technical capacities at the community levels.

**Strategic Data and Information Management:** The various technical reviews speak of a need for a general scale up of monitoring and evaluation activities to further meet international standards (human rights and gender sensitive; evidence-informed) and the growing demands of an expanded response. To get more partners to appreciate the value of monitoring, evaluation and research, new levels of advocacy and resource allocation will need to be developed. In addition, challenges related to the incorporation of M&E into the planning processes as well as to the presence of professional skills levels in M&E and data analysis remain to be addressed effectively. To increase the M&E function throughout the national response scaled up sensitization of partners and stakeholders around the use of specialized M&E tools such as the burgeoning Unique Identifier Code and the scaling up of referral and counter referral systems needs to occur. There are numerous systemic challenges that prevent an efficient flow of data from the point of generation to conclusions, recommendations and dissemination. The BHIS has seen significant improvements but needs further strengthening in relation to HIV-AIDS data. Additional constraints in the area of research for national response issues include the limited national research capacity. A more in-depth understanding of the epidemic needs to be achieved in order to influence its evolution more strategically.

**Chart 7: Problem Tree Analysis for Addressing Critical Enablers (Part 1)**

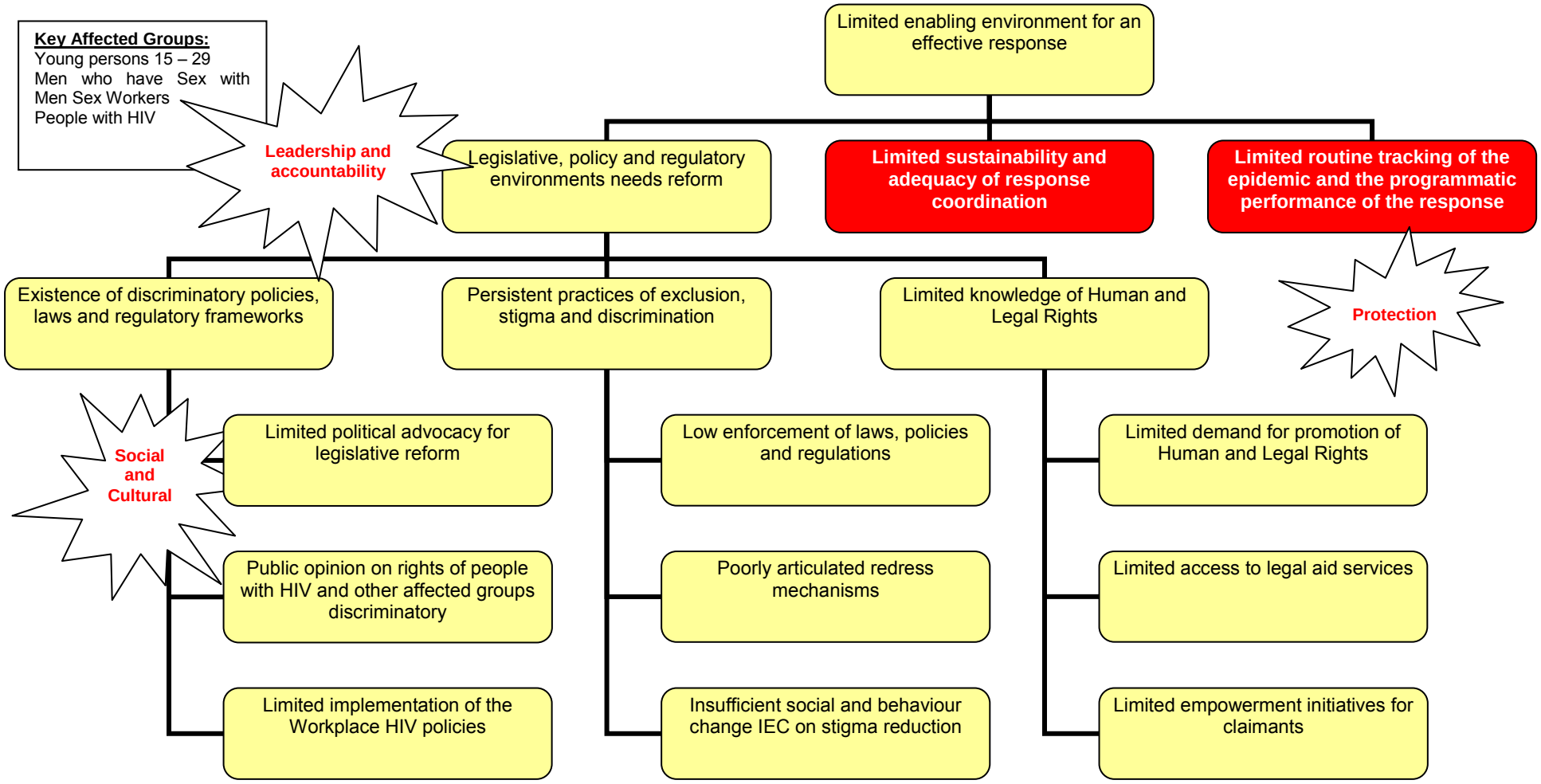


**Chart 8: Problem Tree Analysis for Addressing Critical Enablers (Part 2)**

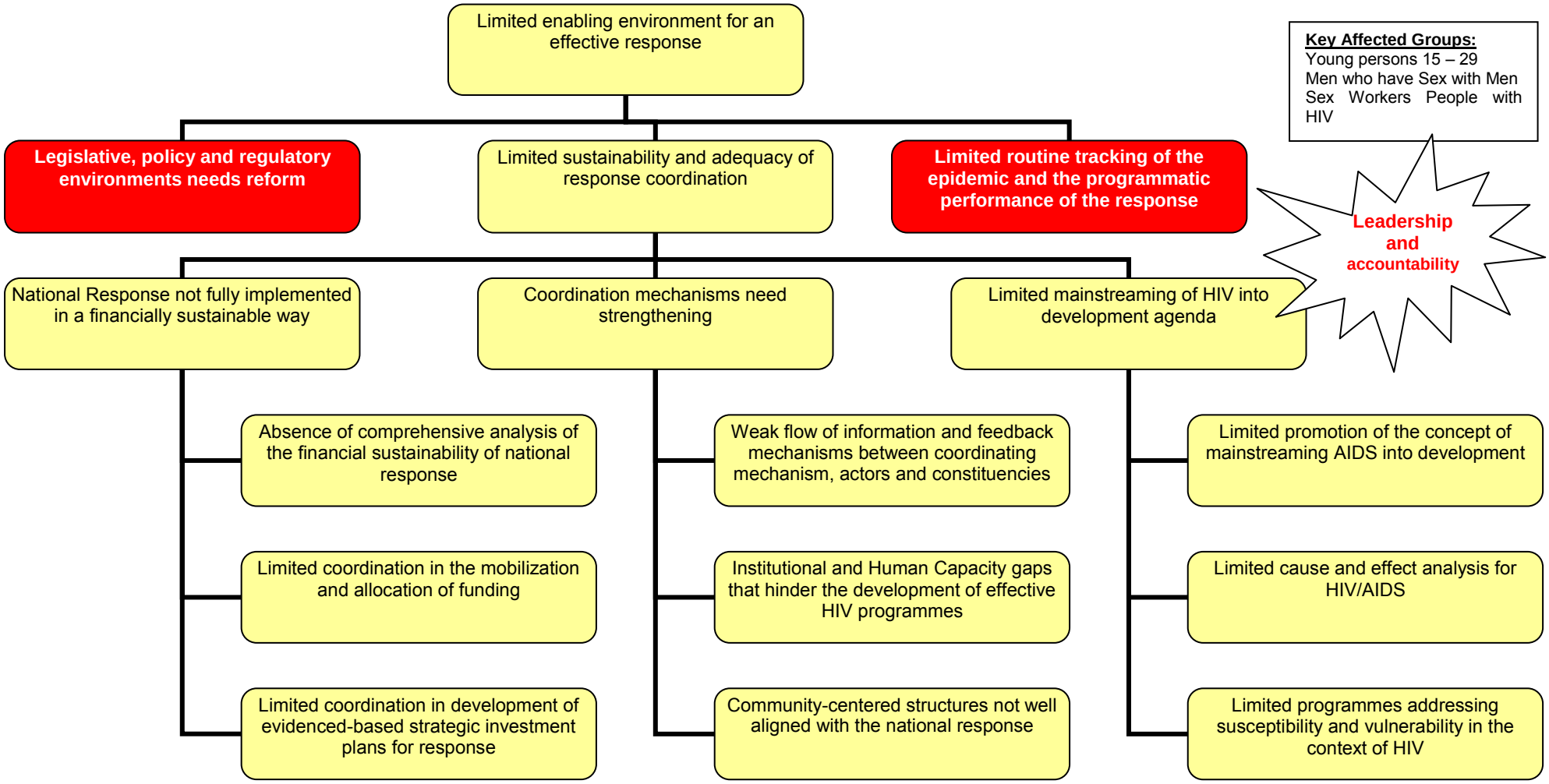
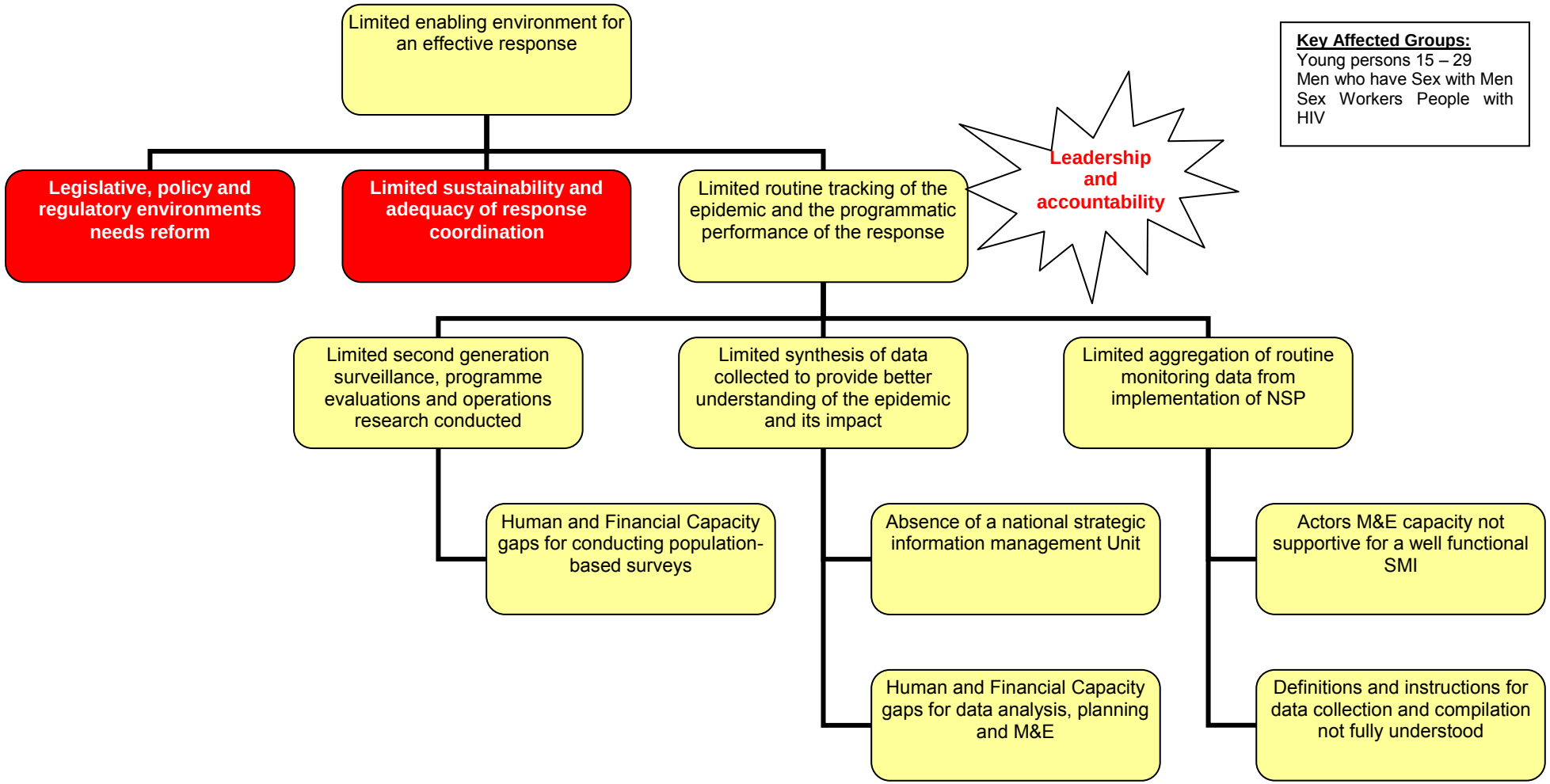


**Chart 9: Problem Tree Analysis for Addressing Critical Enablers (Part 3)**



# Chapter 5 The National Strategic Plan 2012 – 2016

## *5.1 The Guiding References and Principles*

The 2010 Belize MDG Report[46] cites that with refinement of current health investment packages, the country can be on track to achieve the target of halting and reversing the spread of HIV by 2015. Challenges in reaching targets are often attributed to real or perceived stigma and discrimination. Moreover, the data gaps in respect to vulnerable groups hamper the monitoring of progress made. On-going efforts to remedy this are essential for better characterization of the epidemic, and informing decision-making and evidence-based planning. Along with the many social and economic challenges faced by the country, Belize has been experiencing an HIV epidemic that is increasingly posing a burden on the health care system.

The direction and content of NSP are guided by a number of principles and critical assumptions:

- It applies a **human rights-based approach** and focus and is aligned with the part II of the Fundamental Rights and Freedoms (and its Protection) of the Constitution of Belize and with the International Human Rights Conventions and related instruments that have been signed and ratified by the Government. These principles also constitute the foundation of the National HIV Policy.
- References provided by the **ILO Recommendation** concerning HIV/AIDS and the World of Work (2010) and the **2011 Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS.**
- The main thrust of the **Convention of the Rights of the Child** to respect, protect and fulfil the survival, development and participation rights of the child.
- The principle of **gender equity and non-discrimination** establishing that all responses to HIV shall ensure that no person will be denied access to or will remain excluded from prevention knowledge, skills and services or treatment, care and support services on the basis of the real or perceived HIV status, sexual orientation, gender, age, disability, beliefs, socio-economic status, geographic location and level of literacy.
- The **"Three Ones" principle** provides guidance for the effective layering of the response systems.
- Multi-sectoral and multi-stakeholder participation, coordination and management in the development, implementation, monitoring and financing of the NSP, guided by a shared vision, responsibility and set of priority strategies, identified on the basis of evidence and study.
- Committed leadership, professional ethics and confidentiality.
- The acknowledgement that the response will need to enhance sustainability and cost-effectiveness.
- The overall structure in the NSP 2012 – 2016 for capturing and describing the intended

[46] Draft Scorecard and Outlook Report 2010, Millennium Development Goals, Belize; 2011, UNDP in collaboration with National Human Development Advisory Committee

directions and interventions will depart from the schedule of Priority Areas of the NSP 2006 2011.

To provide visibility and space for the articulation of the imperatives for the NSP 2012 -2016, the following Priority Areas will be used:

- Ending New HIV Infections
- Improving Health and Wellbeing
- Creating an Enabling Environment

## *5.2 The Characteristics of the National Strategic Plan 2012 - 2016*

### The Vision

**By the end of 2016, Belize will have continued to reduce the number of new HIV infections; extended the length and quality of life of people with HIV and their families; significantly reduced discrimination against persons vulnerable to HIV; and effectively coordinated a multi-sectoral response which is human rights based and gender responsive**

### The Overall Goals

**By 2016, Belize has halted and begun to reverse the HIV incidence rates among young people, men who have sex with men and sex workers.**
**By 2016, the AIDS-related deaths, especially among men living with HIV in Belize, will have decreased by 30%.**
**By 2016, systems will be in place to fully understand the essential features of the epidemic in Belize.**
**By 2016, Belize will have significantly reduced discrimination against persons vulnerable to HIV.**

### The Specific Goals

**Ending New HIV Infections**

1. Reduced risky sexual behaviour and adoption of personal protection plans for those most vulnerable to HIV.
2. At least an average 10 % annual increase in the number of men and women consenting to HIV testing and returning for their results.
3. Annual increases of 10 (ten) % in reported use of condoms and lubricants by persons 15 – 49, MSM and FSW.
4. The delivery of the Comprehensive Sexuality Education Curriculum has an effective coverage of 100 % of boys and girls enrolled in primary education and 60 % of boys and girls enrolled in secondary education.
5. Ensure that all victims of sexual violence are afforded post HIV exposure and anti-pregnancy prophylaxes, sexual infection testing and treatment, legal and psychosocial support.

**Improving Health and Wellbeing**

6. Increase in the coverage of ART of persons requiring ART based on national treatment guidelines HIV to 85 %.
7. A minimum of 10% annual increase in the number of vulnerable persons, including OVC, utilizing care and support services, including psycho-social support services.

**Creating an Enabling Environment**

8. All relevant legislation reviewed and revised for concordance with the National HIV Response and the enforcement of non-stigma and non-discrimination principles.
9. A minimal increase of 10 % of annual resources (people, funds and materials) available to civil society organizations to deliver NSP interventions to key at-risk populations.
10. Improved monitoring, evaluation and operational research will have provided accurate population estimates, biological and behavioural prevalence data and in-depth knowledge about determinants of HIV vulnerability among key populations.
11. More government partners (Finance, Tourism, Police, Attorney General) recruited into the national response to enhance mainstreaming of HIV/AIDS

## *5.3 The Results Framework of the HIV National Strategic Plan 2012 – 2016: Priority Areas, Principal Strategies, Strategic Objectives and Expected Results*

| Priority Area 1<br>Ending New HIV Infections | | | | |
|---|---|---|---|---|
| Principal Strategies<br>• Design cutting-edge, evidence-informed interventions for sexual behaviour change, especially among identified vulnerable groups.<br>• Reduce barriers to wide-spread HIV-testing in key affected populations.<br>• Establish systems to produce and sustain a national profile of transmission to guide prevention interventions.<br>• Implement socialization programs to mitigate negative cultural norms that increase the risk of HIV transmission such as those that facilitate gender-based violence. | | | | |
| Strategic Objective 1.1<br>To revolutionize and engender evidence-based and targeted social and behaviour change programmes | | | | |
| Expected Result 1.1.1<br>Age appropriate health and family life education programmes delivered in all education institutions. | Expected Result 1.1.2<br>Targeted Social and Behaviour Change initiatives to address high risk sexual behaviour among young people 15 – 29, MSM, SW, prisoners, persons with disabilities, migrants and persons with HIV delivered. | Expected Result 1.1.3<br>Safe-sex negotiation skills strengthened, particularly among girls and women | Expected Result 1.1.4<br>Increased number of HIV prevention initiatives that focus on greater involvement of males in the HIV response | Expected Result 1.1.5<br>Culture of tolerance and respect for gender equity.<br>Men demonstrate responsibility for all facets of their sexual behaviours. |
| Strategic Objective 1.2<br>To achieve universal access to testing and counseling services for key affected populations (MSM, SW, pregnant women, young people and incarcerated populations via targeted PITC and VCT. | | | | |
| Expected Result 1.2.1<br>Increased number of persons most vulnerable to HIV who know their status for HIV and other STIs. | | Expected Result 1.2.2<br>Zero new HIV infections in children under 5 years old | | |

| Priority Area 2<br>Improving Health and Wellbeing | | | | |
|---|---|---|---|---|
| Principal Strategies<br>• Improve access to quality HIV treatment, care and support services.<br>• Improve overall parameters of clinical management of care and treatment services for HIV, other STIs and OIs (including TB).<br>• Implement treatment education initiatives for people with HIV and those most vulnerable to HIV infection. | | | | |
| Strategic Objective 2.1<br>To guarantee equitable universal access to effective HIV treatment, care and support services. | | | | |
| Expected Result 2.1.1<br>Persons in need of ART have access to simplified and optimal treatment regimens. | Expected Result 2.1.2<br>Increased access to diagnostic services for HIV testing, CD4 counts, viral load testing and monitoring of other STIs and OIs. | Expected Result 2.1.3<br>Integrated nutritional guidelines and support for persons with HIV. | Expected Result 2.1.4<br>Improved capacity of health facilities to provide effective and integrated service delivery. | Expected Result 2.1.5<br>Reduced cost of HIV treatment through efficiency gains. |

| Strategic Objective 2.2<br>To ensure effective clinical management of HIV, other STIs and opportunistic infections (including TB/HIV co-infections). | | |
|---|---|---|
| Expected Result 2.2.1<br>Strengthened capacity to implement TB/ HIV collaborative activities. | Expected Result 2.2.2<br>Improved diagnosis and treatment of other STIs and opportunistic infections in persons with HIV. | Expected Result 2.2.3<br>Improved clinical management of HIV across the continuum of care. |
| Strategic Objective 2.3<br>To improve access to and uptake of comprehensive information, education and communication initiatives for persons with or affected by HIV | | |
| Expected Result 2.3.1<br>Persons with HIV educated about clinical management of HIV, drug regimens, support and adherence strategies. | Expected Result 2.3.2<br>Persons with HIV empowered to drive the agenda forward toward better health, security and dignity. | Expected Result 2.3.3<br>CBOs effectively demanding and delivering HIV prevention, treatment, care and support within the framework of the Continuum of Care. |

| Priority Area 3<br>Creating an Enabling Environment | | | |
|---|---|---|---|
| Principal Strategies<br>• Improve access to law and legal services<br>• Reduce and mitigate the impact of stigma and discrimination<br>• Reduce legal or policy barriers to equal opportunities and universal access<br>• Systematic mainstreaming of a high quality HIV response in sector plans to enhance a sustainable response<br>• Strengthen the HIV/AIDS surveillance and compilation and processing of data, disaggregated for sub-populations.<br>• Conducting further research in relation to the characteristics of the epidemic and the effectiveness of the response. | | | |
| Strategic Objective 3.1<br>To mobilize communities around and improve access to HIV related legal services to reduce the stigma and discrimination associated with HIV and vulnerable groups | | | |
| Expected Result 3.1.1<br>Improved knowledge on rights and laws in the context of discrimination based on HIV status, gender, and/or sexual orientation. | Expected Result 3.1.2<br>Improved access to legal support (including women, girls, care-givers, OVC, SW, MSM and survivors of gender based violence). | Expected Result 3.1.3<br>Human rights training institutionalized for key professional service providers including educators and school administrators. | Expected Result 3.1.4<br>Networks of people with HIV and community-based groups are delivering stigma and discrimination reduction programmes. |
| Strategic Objective 3.2<br>To reduce legal and policy barriers in order to achieve Universal Access. | | | |
| Expected Result 3.2.1<br>Laws, policies and regulatory frameworks that are discriminatory to MSM, SW, young persons and persons with HIV are removed, repealed or replaced by new anti-discrimination legislation. | Expected Result 3.2.2<br>Mechanism for reporting violations of the right to equal access to services clearly described in policy and legislative frameworks. | Expected Result 3.2.3<br>Workplace policies and programmes have expanded into the formal and informal employment sectors. | |

| Strategic Objective 3.3<br>To develop and apply new management approaches for improved efficiency and effectiveness of a sustainable national HIV response | | | |
|---|---|---|---|
| Expected Result 3.3.1<br>HIV programmes are routinely monitored and evaluated through a key performance indicator system to ensure optimal programme effectiveness and efficiency. | Expected Result 3.3.2<br>Equitable distribution of qualified health personnel to effectively deliver on the mainstreaming of HIV services in the health care system. | Expected Result 3.3.3<br>Financial Sustainability HIV response resources needs are being stabilized and are predominantly being provided through the national sectoral budgets. | Expected Result 3.3.4<br>HIV services are integrated into existing administrative, legal and social protection machineries in order to promote access to affordable and cost-effective prevention, treatment, care and support. |

| Strategic Objective 3.4<br>To strengthen the strategic information management capacities of the national HIV response. | | |
|---|---|---|
| Expected Result 3.5.1<br>Second generation surveillance, synthesis studies and operational research for outcome and impact monitoring. . | Expected Result 3.5.2<br>Expanded use of national health and non-health programme monitoring mechanisms. | Expected Result 3.5.3<br>Strategic information on key populations to inform programming and policy development |

# Chapter 6 Monitoring, Evaluation and Indicators for NSP 2012-2016

## *6.1 Monitoring*

The NAC is responsible for the monitoring of the implementation of the NSP 2012 – 2016 and will receive technical guidance and support from the Sub-Committee for Monitoring and Evaluation and the relevant staff of the Secretariat. The Sub-Committee, with the support of the Secretariat, will manage and safeguard a calendar and schedule of activities that will result in the comprehensive compilation of progress monitoring data, adopted in the Indicator Framework of the National HIV Monitoring and Evaluation Plan, which is the guide and tool for the monitoring and evaluation of the NSP. The composition of the Sub-Committee and any ad-hoc platforms will mirror the multi-sectoral stakeholder-ship of the national response.

The Commission will receive and examine the reported progress and constraints on a semi-annual basis. Progress Monitoring reports to the Commission, its assessments and recommendations, and any reports from surveys, studies and research, will serve as input into the schedule of documented period reviews. These reviews can result in adaptations to the NSP and/or NOP.

## *6.2 Evaluation*

Evaluations will be undertaken as projected in the calendar of monitoring and evaluation activities for the period 2012 – 2016. The scope of evaluations can move through the various results levels of the NSP (Outputs, Outcomes, Impact). The evaluation schedule will contain a minimum of one comprehensive evaluation of the NSP, to be undertaken at the end of the implementation period of the NSP. The evaluation will ascertain the effectiveness of the NSP.

## *6.3 The National HIV M&E Plan*

This plan will be the guide and tool for monitoring and evaluating the NSP and the NOP. The plan will consist of three key elements:

**The Indicator Framework:** This framework prescribes and describes the indicators, at the various levels, that will be collected, compiled, analyzed and included in reports. Each indicator will be provided with information that speaks to the specific features and characteristics of that indicator: definition, type of indicator, base line value, target value, measuring instruments, responsible entity.

**The M&E Calendar:** This calendar will delineate the various phases and sub-activities in the process of collecting, compiling, analyzing and disseminating reports as well as the process points where data will be used for planning and review purposes.

**Major Activities:** This component provides a time line on which major M&E-related activities are inserted. These activities are events that are under the management of the NAC (review and planning events, mid-term or final evaluation of NSP, surveys, studies, research) or that are driven by external sources (Census, CPA, national / regional studies, etc.).

## *6.4 The National M&E System*

The operationalization of the national M&E system is expected to deliver a fully functional system that provides timely, accurate and pertinent data. The national M & E system, which is built on an overall determination of the flow of data from collection to dissemination and use, contains critical M&E components:

**Surveillance:** the ongoing collection and reporting of data relevant to HIV/AIDS epidemic. Emphasis has been placed on initiating a second-generation surveillance for the ongoing tracking of risky sexual behaviours. The Caribbean region is considering initiating a third-generation surveillance, which aims to track the level, quality and impact of services rendered to persons with HIV and those affected by HIV.

**Referral and Client Management Tracking Systems:** tracking the movements (or lack thereof) within the continuum of care to clients and measures the effectiveness of the coverage and quality of services.

**Project Implementation:** Progress reports offer response updates to all stakeholders and point to areas of additional technical support or planning. Monitoring and evaluation of this kind poses challenges across the board. .

**Research:** Surveillance is to be complemented by essential operational research including epidemiological, evaluation and social impact research. The NAC has a strategic role in advocating for more planned research activities as well as collating, interpreting and disseminating research information. Critical partners are academic research institutions, domestic or international.

**Financial Management M&E:** an important component of a comprehensive M&E system is a finance system that tracks all resources and that can account for funds in a transparent and consistent manner. This system is critical, offering detailed information about committed national

and donor investments and allowing the identification of resource gaps and resource mobilization efforts.

## *6.5 The Key Indicators of the NSP 2012 - 2016*

The table below displays the key indicators of the NSP 2012 – 2016. Some are indicators at impact level, while others are at outcome or output level. The National M&E Plan will further articulate the indicator framework and will incorporate all output and process indicators that will be deducted from the NOP.

| No. | Priority Area / Strategic Objective | Indicator | |
|---|---|---|---|
| | | Impact | Outcome/ Output |
| 1 | **Priority Area 1 Ending New HIV Infections** | Percentage of young women and men aged 15-24 who are HIV-infected | |
| | | Percentage of most-at-risk persons who are HIV-infected | |
| 1.1 | To increase the uptake of early ante-natal care by all pregnant women and their families | Percentage of infants born to HIV-infected mothers who are infected. | Percentage of pregnant women who were tested for HIV and know their results |
| | | | Percent of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission |
| 1.2 | To achieve universal access to testing and counseling services for HIV and other STIs. | | Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results |
| | | | Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their result |
| 1.3 | To revolutionize and engender targeted behavioural change programmes | | Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 |
| | | | Percentage of men reporting the use of a condom the last time they had anal sex with a male partner |
| | | | Percentage of female and male sex workers who report the use of a condom with their affective clients |
| | | | Percentage of women and men aged 15-49 who have had sexual intercourse with > 1 partner in the last 12 months |
| | | | Percentage of women and men aged 15-49 who had more than one sexual partner in the last 12 months reporting use of a condom during their last sexual intercourse |
| | | | Number of free male condoms distributed to end-users in last 12 months |
| | | | Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission |
| | | | Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission |
| | | | Number and percentage of enterprises implementing an HIV workplace program |

| No. | Priority Area / Strategic Objective | Indicator | |
|---|---|---|---|
| | | Impact | Outcome/ Output |
| **2** | **Priority Area 2 Improving Health and Wellbeing** | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | |
| 2.1 | To guarantee equitable universal access to effective HIV services. | | Percent of adults and children with advanced HIV infection receiving ART |
| | | | Number and percentage of people starting antiretroviral therapy who picked up all prescribed antiretroviral drugs on time |
| 2.2 | To ensure effective clinical management of opportunistic infections, including TB/HIV infections | Percentage of newly registered TB patients who are HIV positive | Percentage of persons with HIV on ART, tested for an opportunistic infection and treated if necessary |
| 2.3 | To improve access to and uptake of comprehensive information and support services for persons living with or affected by HIV/AIDS. | | Current school attendance among orphans and among non-orphans aged 10-14 |
| | | | Percentage and number of OVC (0-17) whose households received free basic external support in caring for the child |

| No. | Priority Area / Strategic Objective | Indicator | |
|---|---|---|---|
| | | Impact | Outcome/ Output |
| **3** | **Priority Area 3 Creating an Enabling Environment** | | |
| 3.1 | To reduce legal and policy barriers in order to achieve Universal Access. | | Percentage of laws, polices or legislation discriminating or fostering stigma and discrimination toward most vulnerable populations that have been removed or repealed |
| | | | National Composite Policy Index |
| 3.2 | To reduce the stigma and discrimination associated with HIV and vulnerable groups. | | Percentage of persons 15-49 expressing accepting attitudes towards persons with HIV |
| 3.3 | To develop and apply new management approaches for improved efficiency and effectiveness of a sustainable national HIV response | | Percentage of oversight, review and planning activities in M&E plan completed, over a twelve month period |
| | | | Trend of the annual HIV resource needs gap |
| | | | Number of CSOs involved in National Response with consolidated budget and staffing levels |
| 3.4 | To promote a gender-sensitive response to HIV | | Percentage of victims of sexual abuse who are tested for HIV and other STIs and who are treated if necessary. |
| 3.5 | To strengthen the strategic information management capacities of the national HIV response. | | Percentage of HIV information reports required in National M&E Plan completed over a twelve month period |
| | | | Performance of the HIV national research agenda |
| | | | Behavioral and sero-prevalence data on critical groups available |

# Chapter 7 The National Operational Plan

## *7.1 The National Operational Plan*

This second NSP is being accompanied by a National Operational Plan (NOP) that descends to the level of concrete actions in each of the priority areas. It is focused on the activities that deliver outputs to contribute to the achievement of the higher level outcomes.

The structure and format of the matrices of the NOP, which are based on UNAIDS ASAP Guidelines, uses the cascading order Priority Areas, Outcomes, Outputs, and Activities and provides to each activity the specific attributes Expected Result, Indicator, Time Frame and Owner(s). Specific activities of ongoing major projects (e.g. PEPFAR and GFATM Round 9 grant to CCM) are also incorporated into the NOP to ensure coordination and synergy with the national priority areas and expected outcomes.

## *7.2 The Costing and Financing of the NOP 2012 – 2016*

The national response to HIV/AIDS as defined in the NSP 2012 – 2016 and the NOP 2012-2016 will be costed on the basis of the Resource Needs Model; this exercise is scheduled to take place early 2012 as part of this larger strategic planning process. This model calculates the total resources required to implement HIV/AIDS interventions on a national level and is primarily used for national strategic planning efforts. The model and methodology are very flexible, and can be adapted for use in countries with concentrated or generalized epidemics, and for a range of responses. This model is used to calculate the resource needs of a country based on local decision making. The NAC and its partners will establish a Resource Mobilization Team to consider the resource needs and costs of the national response.

GOB is the single largest contributor to the national response to HIV/AIDS. The country has forged partnerships with multilateral and bilateral agencies and international non-profit organizations that provide financial and technical support for the strengthening of the national response. The forecast for external funding and financing opportunities, especially for Middle-Income Countries like Belize, signals a need to shift the point of gravity from an external funding base to a sustainable combination of mainstream-based domestic funding, complemented by targeted external funding for the strengthening of specific functions. The Resource Mobilization team will be tasked with identifying and assessing innovative approaches to sustainable financing and resource mobilization. These approaches may include cost-reductions and cost-sharing, where possible.

## References

**B**

Blackstone Corporation, Report – "Tourism and HIV/AIDS: Capacity Building in the Tourism Sector in Belize". Inter-American Development Bank, 2008

**C**

CARICOM/PANCAP, Caribbean Regional Strategic Framework on HIV/AIDS, 2008-2012

Carrillo, M., Consultations with Vulnerable Populations on Access to Quality of VCT Services in Belize for Female Sex Workers in Belize North and Island of San Pedro, Institute of Reproductive Health Belize, 2008

Carrillo, M., Consultations with Vulnerable Populations on Access to Quality VCT Services in Belize for Men who have Sex with Men, Institute for Reproductive Health, Belize 2008

Carrillo, M., National Composite Policy Index – 2010, National AIDS Commission 2010

Carrillo, M., Stigma and Discrimination Assessment in Belize, 2009

Catzim-Sanchez, A., Situation Analysis of Children with HIV Belize and Stann Creek Districts, Hand in Hand Ministries/UNICEF, Belize 2008

Catzim-Sanchez, A., Formative Assessment: Workplace HIV Education Programme, MOL / PAHO, Belize 2009

Catzim-Sanchez, A.), Draft Sexual and Reproductive health for Sex Workers, Rapid needs Assessment, Ministry of Health and United Nations Population, Belize 2010

Catzim, A. Haylock, D. & Lovell, J., The Right to Protection: The Commercial Sexual Exploitation of Children and Adolescents in Belize. International Labour Office/National Committee for Families and Children, Belize 2006

Catzim, A., Rapid Assessment Update Voluntary Counseling and Testing (VCT) Services in Belize, 2007.

**E**

Ellison, J., Operational Planning for the National HIV/AIDS Strategic Framework in Belize, 2010

**G**

Gough E, Edwards P, HIV sero-prevalence and associated risk factors among male inmates at the Belize Central Prison, Pan-American Journal of Public Health. 2009

Government of Belize and Caribbean Development, Belize Country Poverty Report, 2010

**H**

Hembling, J., Analysis of the Situation and Response to HIV/AIDS in Belize; Mapping the Response, and Policy Inventory, USAID/PASCA 2011

Hoare, I., Hoare, O., & Aldana, J., Sexual Behaviour Survey Report, 2008

**I**

International HIV/AIDS Alliance, Strengthening the National Response to HIV/AIDS in Belize: Final Report, International HIV/AIDS Alliance, Inter-American Development Bank/Oxford Policy Management, Belize 2007

**L**

Lovell J. Stigma and Discrimination: Barriers to Access, Care, and Treatment for People Living with HIV/AIDS in Belize City and Dangriga Town. Belize, Alliance Against AIDS

**M**

Ministry of Health, Serological and Behavioural Assessment of HIV Infection in the Belize Defence Force, 2010

Ministry of Health, Annual Health Report (2008): National TB, HIV/AIDS and other STIs Programme, 2009

Ministry of Health, Belize Basic Indicators 2008, Belize 2009

Ministry of Health, HIV Surveillance in Belize Yearly Report January - December 2009, Belize, 2010

Ministry of Health, National Health Plan 2007-2012. Belize 2006

Ministry of Health, HIV Sero-prevalence in Inmates at the Kolbe Foundation: Belize Central Prison. Belize, 2005

Ministry of Health, National Health Plan: Health Agenda 2007 – 2011, Belize, 2006

**N**

National AIDS Commission (NAC), A National Communication Strategy for HIV/AIDS in Belize, 2006

NAC, Global Fund Proposal 9 – Accelerating the Pace, Reaching Marginalized and Vulnerable Populations, 2009

NAC, National Monitoring and Evaluation Plan of the National Strategic Plan 2006-2011 Belize, 2008

NAC, National Strategic Plan for a Multi-Sectoral National Response to HIV/AIDS in Belize (2006-2011)

NAC, 2010 UNGASS Country Progress Report, Belize, 2010

NAC, Rapid Situation Assessment of Vulnerable Groups to HIV/AIDS in Belize, 2009

NAC, Situation Analysis Desk Study related to Most At Risk Population (MARPs) in Belize, 2010

NAC, National Policy on HIV/AIDS, Belize, 2006

NAC, National Policy on HIV/AIDS in the World of Work, Belize 2005

**O**

Office of Governance, HIV/AIDS Policy of the Public Service of Belize, 2007

Orozco, C. & Gabourel D., Show No Mercy: Barriers that exist for men who have sex with men to access sexual and reproductive services, Belize 2008

**P**

PAHO/WHO, HIV and Violence against Women in Belize Report, Belize, 2010

PAHO/WHO, Gender-based Analysis of HIV in Belize, 2010

PAHO/WHO, Evidence of Gender-based related Risk factors and Impact, 2008

PAHO/WHO and UNICEF, Evaluation of the Health Sector Response to HIV and STIs, 2010

Perera G. National AIDS Spending Assessment (NASA) 2008/2009, Belize: USAID/PASCA, 2010

Prairie Women's Health Centre, Gender-Based Analysis of HIV/AIDS in Belize, PAHO, 2010

Population Service International (PSI), Belize HIV/AIDS TRaC Study Evaluating Condom Use among MSM in Belize District, Corozal, and Orange Walk, 2007

PSI, Belize HIV/AIDS TRaC Study Evaluating Condom Use among Female Sex Workers, 2007

PSI, TRaC Studying Evaluating Condom Use Among MSM in Belize, Cayo, and Stann Creek Districts, 2007

PSI, TRaC Studying Evaluating Condom Use with Occasional Partners among Garifuna in Cayo, Stann Creek and Toledo, 2007

**S**

Sebastian S. Sexual Behaviour Survey Report, Belize, 2009

Sexual and Reproductive Health Policy, Ministry of Health/Government of Belize/Pan American Health Organization, Belize 2002

Shaw, D., National AIDS Commission Legislative review, National AIDS Commission, 2008

Statistical Institute of Belize, Mid-year Population Estimates, 2009

Statistical Institute of Belize, Mid Year Population Estimates, Belize 2009

**U**

USAID/PASCA, AIDS Policy Index Report, 2010

USAID/PASCA, Policy Implementation Monitoring Report, 2011

UNAIDS, Keeping the promise: Summary of the Declaration of Commitment on HIV/AIDS, 2001

UNAIDS, Preparing National HIV/AIDS Strategies and Action Plans - Lessons of Experience, ASAP 2007

UNAIDS, Improving HIV/AIDS Strategic and Action Planning --Lessons Learned from Lead Consultants, ASAP, 2008

UNAIDS, "Three Ones" Key Principles: Coordination of National Responses to HIV/AIDS, UNAIDS, 2004

UNAIDS, Terminology Guidelines, 2011

UNDP, Supporting National HIV Responses: An Implementation Approach, 2007UNDP, Millennium Development Goal Score

NAC National AIDS Commission
*Responding to HIV/AIDS in Belize*

USAID FROM THE AMERICAN PEOPLE | PASCA Program for Strengthening the Central American Response to HIV

UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK